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PUBLIC HEALTH AND INSURANCE ASPECTS OF AMEBIASIS

A NOTE ON CERTAIN ERRONEOUS CONCEPTS

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NEW ORLEANS

At the present time amebiasis occupies the anomalous position of being underestimated as to incidence, overestimated as to lethal possibilities, and largely mismanaged from the standpoint of public health. Physicians who treat diseases of the colon would be in general agreement with these statements. Those who do not might perhaps be inclined to dispute them.

INCIDENCE

The incidence of amebiasis in the United States is now usually set at about 10 per cent, which means that between 13 and 15 million persons suffer from the disease. In the colder northern portions of the country the incidence is probably somewhat lower. In warmer portions, such as Louisiana, it is higher. Faust's studies in New Orleans, which revealed an incidence in the neighborhood of 16 per cent, are probably typical for this part of the country.

The known or apparent incidence of amebiasis is directly related to four factors: the climate, the competency of the examiner, the type of stool examined, and the number of times the examination is repeated. Diagnosis is entirely a laboratory matter. Physical examination, except in amebic hepatitis and amebic abscess of the liver, is not helpful, and the history, while it arouses suspicion as to the existence of the condition, supplies no conclusive information.

The fact that the diagnosis of amebiasis is considerably easier to establish in a warm than a cold climate means that the known incidence of the disease is likely to be higher in a warm than a cold climate. For this situation there are at least two reasons. The first is that the number of parasites per unit of stool is usually materially larger in a warm than in a cold climate. This is clearly proved in a warm climate, such as New Orleans, when the seasons change. It is far more difficult here to establish a positive diagnosis by the identification of *Endamoeba histolytica* in winter than in summer because the parasites are less numerous in the winter.

The second reason why the diagnosis of amebiasis is often simpler in warm climates than in cold is the fact that the disease more often assumes a dysenteric form in such climates, and thus directs attention to itself. A patient with dysentery cannot ignore his symptoms; he must have medical attention. A patient with less severe manifestations, including diarrhea, may ignore his disease or may serve as his own physician. Dysentery is quite frequent in the tropics, much more frequent than it is in a subtropical climate such as that of New Orleans. In New Orleans, on the other hand, while amebic dysentery is not at all frequent, it is seen more often than in Salt

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Lake City, for instance, or Portland, or the New England States. For that matter, all symptoms are milder in winter and in cold climates than they are in summer and in warm climates.

The competency of the examiner ultimately determines the number of diagnoses made. This is not a task for a tyro. Craig has repeatedly stated that for a physician (or technician) to diagnose 90 per cent of the cases of amebiasis which come under his observation he must undergo a training period of at least two years, under qualified supervision, and must examine thirty to forty stools each day during this period.

The type of specimen examined has a great deal to do with the number of cases diagnosed. Sawitz, for instance, demonstrated that the efficiency of a single purgative specimen is equivalent to that of three normally passed stools. Examination of material aspirated from the colon at sigmoidoscopy is even more efficient, provided that the patient has been properly prepared. A single negative report cannot be accepted at its face value. Repeated examinations, at intervals of five to seven days, are necessary because the output of cysts is cyclic. The wet film preparation is to be preferred to the more elaborate hematoxylin eosin preparations for identification of trophozoites. The zinc sulfate centrifugal flotation technic is the method of choice for identification of cysts. One reason the diagnosis of amebiasis is missed so often is that, except in special laboratories, normally passed stools are more often examined than other specimens, and that a single negative examination is accepted as conclusive.

Figures for the Lakeshore Hospital in New Orleans for the twenty-three month period extending from July 17, 1946, to June 16, 1948, throw a good deal of light upon the statements which have just been made. During this period 9,675 patients were admitted to the hospital for all causes. Stool examinations were requested on 928 of these patients, from whom 1,143 specimens were examined, an average of 1.2 per patient. Presumably the referring physicians had reason to suspect disease of the colon in most of these patients, though the reasons for the request for the examination were not usually known. An occasional specimen was secured by aspiration at proctoscopy and a number were purgative or enema specimens. Most often, however, normally passed stools were examined. *Endamoeba histolytica* was identified in 179 of the 928 patients, 19.3 per cent.

Over the same twenty-three month period I personally saw 1,479 adult patients in private practice, primarily for investigation of possible disease of the colon. On these patients 6,322 examinations were made, an average of 4.3 per patient. A few of the specimens were normally passed stools. The great majority were purgative or enema specimens or material secured by aspiration at sigmoidoscopy. *Endamoeba histolytica* was found in 971 of the 1,479 patients, 65.6 per cent.

Finally, over the same twenty-three month period 392 children under 12 years of age were seen by the writer in private practice. They had been referred chiefly for investigation of possible disease of the colon, or because of enlargement or tenderness of the liver, or for both reasons. In these cases 1,917 specimens were examined, an average of 4.9 per patient. A few of the specimens were normally passed stools. The greatest number were purgative or enema specimens or material secured by aspiration at sigmoidoscopy. *Endamoeba histolytica* was found in 268 of the 392 children, 68.3 per cent.

The comparative percentages of positive diagnoses in these three groups of patients are interesting and significant. In the first group of hospital patients, about whom very little is known, examinations were seldom repeated and the most efficient specimens were not usually presented for study. Only 19.3 per cent of the patients were found to harbor *E. histolytica*. In both the adult and children's groups of private patients the most efficient specimens were usually used for examination, and examinations were repeated many times. Of the adult private patients, 65.6 per cent were

found to harbor *E. histolytica*, which was identified in 29 per cent of the specimens examined. Of the children, 68.3 per cent were found to harbor *E. histolytica*, which was identified in 28 per cent of the stools examined.

It must be granted that disease of the colon was suspected among the private patients and that the suspicion was the reason for the examination in most cases. This may or may not have been true of the patients examined for other physicians in the laboratories of tropical medicine at the Lakeshore Hospital. The extremely high—and almost identical—proportion of positive results in the adult and children's groups of private cases is, however, in sharp contrast to the relatively low proportion of positive results in the general hospital group. The difference can be explained in part by the differences in the types of specimens examined, while the relatively small proportion of positive results in the total number of specimens examined in the general hospital group is clear proof of the importance of repetition of the studies. Special attention should also be called to the number of positive cases among children, in whom, until quite recently, the disease was believed to be very infrequent.

PUBLIC HEALTH ASPECTS OF AMEBIASIS

Amebiasis in Louisiana, and probably elsewhere, is a reportable disease which is not being reported. It is unlikely to be generally reported until public health authorities change their point of view concerning it. In Louisiana, as soon as the disease is reported by the physician in charge of the case, a social service worker is sent to the patient's home to interrogate him. Most of the inquiries are useless. Any information thus obtained is already in the files of the reporting physician. These inquiries have, however, the effect of embarrassing the patient, and of arousing resentment in him because he is put in the position of being a public health menace.

Actually, he is no such thing. He is under treatment and his disease is in process of being controlled. The public health menace is not the patient who is being treated. The danger to the public in respect to amebiasis comes from two sources: (1) the patient whose disease has not been diagnosed and (2) the patient whose disease has been diagnosed but who refuses treatment or who will not return for adequate post-treatment follow-up. These are the patients who are dangerous to the community and they are the ones who should be the concern of the public health authorities.

A similar anomalous situation prevails in the schools. A child whose disease is reported is immediately shut out from school by the school authorities, and out of school he must remain until his disease is cured, which may be a matter of months. Because he is under treatment he is not a menace to his companions. Yet he is, in effect, penalized for being treated. In the same school, on the other hand, there are undoubtedly many children with undiagnosed amebiasis. These children are not being treated for their disease; they take no precautions concerning personal hygiene; and they are unquestionably spreading the infection. They furnish the real menace. Unless, therefore, some attempt is made by the school medical authorities to identify all the children in the school with the disease, to penalize the child who is under treatment is an unjust and thoroughly absurd situation.

THE LETHALITY OF AMEBIASIS

Precisely the same situation that prevails in the schools prevails when the patient with amebiasis attempts to secure insurance. If he tells the truth, he suffers. Some insurance companies raise the premium under these circumstances. Other companies require that the patient wait until cure is assured, usually for a period of two years, before insurance is granted at the standard rates.

Insurance companies naturally must protect themselves and their clients by careful inquiry into the previous history and current medical status of applicants for insurance. The possible longevity of an applicant who has had various diseases is of natural concern to them. They could not maintain their solvency if they did not take careful

account of such matters. Their fear is apparently that a patient who has amebiasis may develop hepatitis or liver abscess or both. It is true that both are serious conditions, especially the latter, but the situation should be surveyed in its true perspective before conclusions are drawn.

The facts of the matter at this time are about as follows: (1) The incidence of hepatitis and liver abscess has decreased notably since the introduction of effective amebicides. (2) A patient under treatment for amebiasis is highly unlikely to develop liver abscess; I have myself never seen this happen. Hepatitis, while a possibility, is also an unlikely development in a patient under treatment. (3) Should these complications develop, the fact that the patient is under treatment means that they will be diagnosed promptly and treated vigorously. (4) It is a curious but generally established fact that patients who develop amebic liver abscess, the most serious complication of amebiasis and the most frequent cause of death from it, are likely to be absolutely or relatively well until the abscess develops. They seldom give a history of diarrhea or dysentery. They almost never have been treated for amebiasis. The attending physician, therefore, unless he is aware of the frequency of amebiasis and realizes the insidious character of amebic liver abscess, often does not think of it as a possible cause of continued fever and general debilitation. (5) Unless the examination is made by a well qualified technician and in a special laboratory, *E. histolytica* is unlikely to be recovered in the stools. It is notoriously difficult to identify the parasite in the usual case of amebic liver abscess.

What these various considerations amount to, from the standpoint of the insurance companies, is that their interests are not served by penalizing the patient who is under treatment for amebiasis, or who has been under treatment for it and who honestly states the fact. These patients are not the ones who furnish the mortality in the disease. The mortality is concentrated in liver abscess. Numerous specialists in tropical medicine share my own experience of never having seen a treated private patient die of amebiasis from any cause. If the insurance companies believe that amebiasis is a lethal disease, as their present policies suggest, then their point of view should be followed to its logical conclusion: All patients who apply for life insurance should be adequately checked (which means a great deal more than the examination of a single stool) for possible amebiasis. The number of positive results would probably be surprising.

The crux of the whole matter, in other words, is whether or not a patient with amebiasis has been treated. Even in a temperate climate an untreated infection will have some influence on longevity, just as any other chronic, untreated infection will have some influence on length of life. In the tropics the effect of an untreated amebic infection is even more serious: Most persons in the untreated group may be expected to develop amebic liver abscess or amebic dysentery. On the other hand, in the tropics, just as in temperate regions, a patient who has been treated for amebiasis, who has had a clinical cure, and whose stools are negative at the time of the insurance examination, is a good risk. He should not be refused insurance, nor should he be made to pay higher rates if insurance is granted him. The poor risk is the applicant with unrecognized or untreated disease, though at the present time he receives insurance without question and at the usual rates.

Very little can be found in the literature concerning the insurance aspects of amebiasis. For this reason Cawston's[1] article on the subject, although it appeared in an English medical journal and concerns the disease in South Africa, is of particular interest. In most respects, his point of view is the same as my own: The medical examination at the time of application for insurance is more important than the history of previous infection. If the candidate reveals no local tenderness over the liver, epigastrium, appendix, or descending colon, he is unlikely to be harboring an amebic infection, even if he has a history of previ-

ous infection. Negative laboratory reports, for various reasons, may be deceptive. Deaths caused by amebic infection are decidedly less common than those caused by bacillary dysentery. At least 90 per cent of all infections can be cured if the proper methods are employed. Although insurance of a known amebic cyst-carrier had best be postponed temporarily, experience shows that, since insidious liver abscess has become infrequent, he is more dangerous to the community than to himself. Deaths from amebic infection among insured persons are exceedingly rare. If a patient reports adequate treatment of a diagnosed infection, and if six months have elapsed since there has been any evidence of infection, the case may be regarded as on the same level as a successful cure of bilharzial infection and the candidate may be accepted "as first class without any loading" if no other abnormality has been revealed in the course of a thorough medical examination.

So far as I know, no special attempt has ever been made by workers in the field to show that amebiasis in any way affects longevity. It is well known that as an individual approaches middle life, his chances of contracting the infection become less, not because there are fewer opportunities for exposure to it but probably because an immunity to it develops as the result of previous infections which have undergone spontaneous cure. Whether or not this explantation is valid, the incidence of amebiasis begins to fall as middle life comes on, and it is considerably lower between 50 and 70 years of age than it is in young adult life.

A curious consideration in amebiasis is that the patient with amebiasis is in some respects benefited by having it. Because he suffers from easy fatigability he necessarily moderates his activities. He gets more sleep because he must have more. He drinks less alcohol and he dissipates less, because he cannot stand the pace. This period of lessened activity because of the disease has the contradictory effect of actually lengthening the life span. The statement is made with some hesitancy, because on the surface it does not seem reasonable, but there is repeated evidence of what happens from the standpoint of activity when once a patient with amebiasis is cured of his disease. Once he is cured, or once his treatment is successfully under way, he becomes a normal, healthy individual, able to do all the things that he has not done over a period of years. It should be emphasized, moreover, that cure is possible with proper treatment, no matter how long the patient has had his infection.

It would be interesting to compare the longevity of citizens of such a city as New Orleans, where the incidence of amebiasis is approximately 16 per cent, and that of some of the cities in New England, where it is probably less than half as high. New Orleans has long hot summers. The damp climate causes a high incidence of sinus infections. All types of skin disease that thrive in warm climates are observed here. In the New England States, on the other hand, the upper respiratory infections which once were highly fatal in cold climates are now readily checked by antibiotic and chemotherapeutic methods, so that deaths from that source have been reduced to low figures in recent years. If amebiasis were really a factor in reducing longevity, it would seem that persons in New Orleans would live less long than those in the New England States. It would be interesting to determine whether that is true. My own experience with amebiasis makes it seem entirely unlikely.

SUMMARY AND CONCLUSIONS

Amebiasis is an infectious disease of widespread incidence. Diagnosis, which is entirely a laboratory matter, depends upon the competency of the examiner and the efficiency of the methods employed. Figures from hospital and private practice are cited to confirm these contentions.

The treated patient with amebiasis is not a public health menace. The treated patient with amebiasis is not a poor risk from the standpoint of insurance. Yet in both categories the treated patient is for all practical purposes penalized because his disease has been recognized and he has submitted to

treatment. The person with unrecognized and untreated disease continues to spread infection with impunity. He is definitely a poorer insurance risk than the treated subject because he may develop amebic dysentery or amebic liver abscess, both of which are serious complications. Yet he is granted insurance without question and at the usual rates if he is otherwise qualified.

Both public health authorities and insurance companies would do well to review their present policies in respect to patients with amebiasis and to alter them to conform with the realities of the situation. At the present time they do not. The diagnosis and treatment of this disease are all important from both the public health and insurance standpoints and due regard should be paid to both considerations in the evaluation of the patient with amebiasis, who at the present time is badly in need of a new medical deal.

REFERENCE

1. Cawston, F. Gordon: A note on amoebic infection from a life assurance point of view, Practitioner, 144:282, 1940.

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THE AMERICAN ACADEMY OF GENERAL PRACTICE

WHY THE ACADEMY*

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SHREVEPORT

The development of the American Academy of General Practice was the outgrowth of a definite need. Specialization in all branches of medicine has definitely gone too far. Many men have always felt that they wanted to do general practice,—that they were more capable of doing a general type of practice than a specialty. In many parts of the country general practice is sorely needed, particularly in the rural districts. As a consequence, many general practice groups have developed all over the country. For example, Wayne County, Michigan, has had a general practice group with a large membership for several years. About six local organizations of general practitioners grew up in California. A national organization developed largely located in the states of Wisconsin and Illinois, the American College of Physicians and Surgeons, composed of a very active group who attempted to do something for themselves. The general practice group of Greater St. Louis is another very interesting group that grew up early.

Finally the American Medical Association, realizing that the rural people's needs could be met best by the general practitioner, organized a section on general practice. The first session was held at the 1946 meeting in San Francisco. Dr. Paul A. Davis of Akron, Ohio, our national president, was its first chairman. The meetings of this section were one of the most enthusiastic groups in the whole American Medical Association meeting. Following the discussions during and after this meeting, a committee was appointed to draw up a constitution and by-laws and plans for a national organization, and to report back in Atlantic City in 1947. This was done. Dr. Stanley R. Truman of Oakland, California, was chairman of that committee, Dr. E. C. Texter of Detroit Michigan, Dr. Paul A. Davis of Akron, Ohio, and Dr. W. B. Harm of Detroit, Michigan, were other members of this committee. They studied constitutions and by-laws of every description over the country, about thirty in all, and finally developed the first constitution and by-laws, which were adopted by the Academy at our Organization Meeting in Atlantic City. The secretary of every medical society in the United States was notified by letter that the meeting was to be held on June 10, at the Claridge Hotel, during the American Medical Association Centennial Session. This meeting was attended by one hundred or more general practitioners and the constitution and by-laws were adopted and the present officers were elected: Dr. Paul A. Davis, president; Dr. E. C. Texter, vice-president; Dr. Stanley R. Truman,

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secretary; and Dr. U. R. Bryner of Salt Lake City, Utah, treasurer. Nine directors were elected from over the United States. The writer was one of those so honored.

OBJECTS AND PURPOSE OF THE AMERICAN ACADEMY OF GENERAL PRACTICE

As set forth in the constitution and by-laws, the purposes and objects of this organization are as follows: (1) To establish an organization of general practitioners of medicine and surgery, to promote and maintain high standards for the general practice of medicine and surgery; (2) to encourage and assist young men and women in preparing, qualifying, and establishing themselves in general practice; (3) to preserve the right of the general practitioner to engage in medical and surgical procedures for which he is qualified by training and experience; (4) to assist in providing post-graduate study courses for general practitioners, and to encourage and assist practicing physicians and surgeons in participating in such training; (5) to promote the science and art of medicine and surgery and the betterment of the public health; and to preserve the right of free choice of physician to the patient.

There probably never was a medical organization that met with as much favor as the American Academy of General Practice. The medical press has lauded us to the skies. The American Medical Association has been co-operative. The Board of Trustees, in February, appointed three of their outstanding members to co-operate with the Academy in working out future plans. The lay press has been unusually generous in its publicity. National journals have carried articles and the Medical Times has devoted a section to general practice. Other magazines have been very liberal in their discussion of our aims and purposes. Daily newspapers have helped us in a great many ways. In our own state of Louisiana the press has been very generous in publicizing our organization meetings, and gave full coverage to the Annual Scientific Meeting, which was held April 3-4, 1948, in Alexandria, Louisiana.

THE ACADEMY IS NOT AN ANTAGONISTIC GROUP

The Academy is in no way trying to take the place of any of the specialists. We realize that men who have given years of their lives to one specialty know more about that than the general practitioner. But we do feel that there should be somebody who knows something about all organs of the body and who can treat them all at the same time. Many patients feel that they want a family doctor. They do not want to lose the patient-doctor relationship. The family doctor has definitely not passed out of the picture.

The American Medical Association realized this when they created the General Practitioner Award last year. The gold medal was first awarded to Dr. Archer C. Sudan of Colorado, formerly of Kremmling and at present of Denver. Dr. Sudan was picked from among those doctors all over the United States who most typified the general practitioner or family doctor. I had occasion last summer to pass through Kremmling and talk to some of the residents there about Dr. Sudan. It has been my good fortune to meet Dr. Sudan on several occasions and to have him at our State Scientific Meeting in Alexandria on April 3-4. A man of Dr. Sudan's calibre might not know as much about one individual subject as a specialist, but must know a great deal about all parts of the body. Many of his patients live fifty or seventy-five miles away. He has had to travel in the heat and cold. Many times he has been snowbound and has had to walk through the snow for miles. He has had to treat the patient with what equipment and what drugs he had available.

THE THREAT OF SOCIALIZED MEDICINE

The threat of socialized medicine has also shown us that we need more general practitioners. During the taking of testimony in Congress against the Murray-Wagner-Dingle Bill, the general practitioner was often called upon. The general practitioner gets closer to the patient than the specialist in most cases. Most patients do not care patients do not care whether the specialist is socialized or not, but certainly do not want their family doctor to be socialized. In Washington last year we three general practitioners had occasion to entertain our

own Congressmen from Louisiana. We had a get-together meeting and thrashed out many of the things that they had on their minds regarding the doctors in general. Each one had some grievance against some specialist, but none wanted the status of his family physician molested. In the regimen for socialized medicine, the general practitioner would have little or no place. His part would be only that of a clearing house for the specialists. He would be permitted to treat emergency cases only, make some sort of diagnosis and then send the patient on to the specialist required.

WHAT CAN THE GENERAL PRACTITIONER DO?

A conscientious general practitioner will do those things for which he is specifically trained. We must realize that he has had at least three years in college, four years in medical school, one year in a rotating internship. This certainly must equip him for doing a lot of work. It has been estimated that 85 per cent of all human medical needs can be taken care of by a good, well-trained general practitioner. If he has a special desire to follow some line, he will study and take more courses in that type of work. He will become a little more proficient in that one particular line. This is the way specialists develop. In times gone by there was no such thing as a specialist, but because of special interest the man developed a little more experience in ear, nose and throat work, and, conseuently, became a specialist in that. We are living in an age of specialization and I certainly hope that we will never see that pass. I would hate to live in a town or community in which there were no specialists. I would hate to think that I could not call on some man who did not know more about one part of the body than I do. But, I still think that good general practitioners can do as well an all-around job on the ordinary diseases, as a group of specialists, and certainly, the cost to the patient will be less.

IMPROVED STANDARDS OF THE GENERAL PRACTITIONER

To belong to our organization, we have several qualifications, which are as follows: (1) You must be a member in good standing with your county and state medical societies, and the A. M. A. We do not think that we ought to go into a community and determine who is a good doctor and who is not; the A. M. A. has done that. (2) We require that he be a graduate of a Class A medical school and have at least one year of rotating internship and three years in general practice. We think that after he has met these requirements he should be eligible for our organization. But there is an additional requirement which, we think, makes ours greater, probably, than most of the specialty groups; that is the 150 hours of post-graduate work required every three years to get into our organization and the 150 hours to stay in it. This is mandatory and our rolls will be reviewed every three years. Most of the specialty groups feel that they need some such provision. A good man may get into their organization and never do anything thereafter. But he can stay in the organization for the rest of his life. In our organization this man's attainments will be reviewed every three years and if he has not kept up, he will be suspended and finally retired from the organization entirely.

WHAT THE ACADEMY HAS DONE DURING ITS FIRST SIXTEEN MONTHS OF EXISTENCE

To date thirty-two states have organized, including Louisiana. We hope by the end of the year that we will have all forty-eight states, the District of Columbia, and Hawaii organized as state groups. Later on, we hope to get in a portion or all of Canada. There are approximately seven thousand members on our rolls at the present time and more coming in every day. We hope to have ten thousand by the time of the annual meeting in March. There are many district and county organizations. For example, in Louisiana all of our eight congressional districts are organized on a district basis and are holding regular scientific meetings about every three or four months. Several states have already held a state scientific meeting and the national organization has held one business meeting of the Congress of Delegates in Chicago, June 20-21 this year. Large plans are being made for the first scientific assembly to be held in Cincinnati on March 6-9, 1949.

The program committee has been active in trying to get the best talent possible all over the United States and make this the best program of the year. We are to have a total of nineteen scientific papers and two additional addresses. There will be only one general section, in which the speaker addresses everybody. There will be scientific and technical exhibits and we hope to have the outstanding meeting of the year. At the meeting in Cincinnati on September 15, the Executive Committee, the Scientific Committee, the Technical Exhibit Committee and the Local Arrangements Committee conjointly completed all the details for the meeting. The headquarters will be in the Netherland-Plaza Hotel and I hope that each and every one of you will plan to attend that meeting with your wife. It is planned to have an Auxiliary Organization meeting at that time.

THE FUTURE OF THE AMERICAN ACADEMY OF GENERAL PRACTICE

We think that the future of the American Academy of General Practice is in good hands. I have never belonged to an organization whose officers and directors were as earnest, sincere, and hardworking as the present ones are. They are men of broad experience, of unlimited energy and are outstanding in their own communities. They are working tirelessly getting a good job done well. They have the confidence of the men around about them, whether they are specialists or general practitioners. They have the confidence of the American Medical Association in general. People now know that we are not going off half-cocked, that we have a job to do and that we are trying to do it well. We are not fighting anybody. We are trying to raise the standards of the general practitioner. We are trying to make him a better doctor. In that way we hope to maintain the prestige that he justly deserves.

PROBLEMS THE ACADEMY HOPES TO HELP SOLVE

Incidently, we are going to help answer some problems that are outstanding in medicine at the present time. One of them is, *Rural Health.* Obviously, the rural community has to depend on the general practitioner. Rural people do not want poor, second-rate medical care. They want the best that can be given. We think that this can best be given by a good, well-trained general practitioner. Another problem to be solved is, *Socialized Medicine.* We think that a good, well-trained general practitioner can give good medical care at less cost than several specialists treating the same disease. This leaves the specialists for consultation and for the complicated diseases for which he is trained. *The Program of Our Medical Schools*: We think that medical schools maintained by tax money should be more interested in training good, well-rounded general practitioners. This should be started back even in the undergraduate and continued through the interne training. We believe that since 85 per cent of human ills can be treated by good, well-trained general practitioners, a majority of medical students should be trained along general practice lines. We think that the different departments in medical schools should look forward to training men for general practice rather than a specialty. *Hospital Training*: We think that the first year of internship should be a rotating internship; that the young doctors should be given advantage of all the groups. The training that year should follow, more or less, the plan outlined for medical schools. The plan should still lead toward a career as a general practitioner. Then, if a man wants to take a residency, and many of them will continue to do so, we think every well regulated hospital should have a section on general practice for residency training. According to our plans at the present time, this should be a two year residency. It should contain about equal amounts of medicine, obstetrics and gynecology, surgery, and pediatrics, with small amounts of the other specialties thrown in, as best fits with their program. We think that a young doctor, after he has had these three years of training shiuld be capable of going out into a rural or suburban community and giving the people good medical care. If the community has provided hospital beds, laboratory, and x-ray facilities, along with

the other things that are necessary for good medical care, then we feel sure that such a young man will be satisfied and continue in the general practice of medicine. *Specialists*: Others that want to go into the specialties, obviously, can start out in their residencies at the end of the one year internship. However, there is a growing belief among many general practitioners and specialists that general practice itself, for a three to five year period, should be a prerequisite to specialty training. This will be discussed pro and con in the future and should be thoroughly considered. A man who has done general practice for several years and then goes into a specialty, knows more surely what he wants than if he has done no practice at all. The doctor who has done general practice for a few years should definitely be a better specialist.

WHAT THE ACADEMY MEANS TO THE GENERAL PRACTITIONER

1. It should maintain the physician-patient relationship better than any other group in the world.

2. It should maintain the prestige of the general practitioner in the community in which he lives.

3. It should give the general practitioner a standing among his fellow doctors, similar to that of the specialist.

4. It should increase his financial income. There is no reason why the general practitioner should not make as much money as the specialist, if he is as well-trained and does as good work.

5. It should help him maintain his hospital standing. We do not want a general practitioner to do work on a patient, surgical or otherwise, unless he is equipped. But, if a man is well-trained in surgery of the abdomen and still wants to do general practice, we believe that his right to do abdominal surgery should be maintained by our group.

6. We should stimulate more men to go into the general practice field. Many young men have gone into a specialty simply because it has been the popular thing to do. This should stop.

In conclusion, I wish to state that we are fighting nobody. We intend to work with the American Medical Association, the state medical societies, and the county medical societies to maintain high scholastic standing for our doctors. While we do not want all general practitioners in our group, we want those that are in our group to be the best ones in the community. We expect them to keep up their post graduate work and their standing among their fellow men. If we do this, then we have accomplished a great deal. And last, but not least, we hope to keep the family doctor forever in American Medicine.

MENOPAUSAL BLEEDING

CURTIS TYRONE, M. D.

NEW ORLEANS

In order to appreciate the significance of menopausal bleeding, it would seem necessary first to consider the meaning of the menopause. The menopause may be defined as that period in the life of a woman when menstruation normally progressively declines and eventually ceases. Although cessation of menstruation is the most prominent manifestation, usually associated with this are different degrees of vasomotor, neurogenic, and emotional symptoms. Slight variations in the menstrual flow during the menopause are to be expected but abnormal uterine bleeding at this time demands a careful history, prompt and thorough pelvic examination, and diagnostic curettage when necessary in order to determine the cause before treatment is instituted.

Abnormal uterine bleeding may be caused by almost any pathologic condition which can affect the pelvic viscera. Most often it is a manifestation of such benign conditions as fibroids and fibrosis of the uterus, strictures of the cervix, chronic cervicitis with erosion or eversion, and polyps. However, despite the fact that it is less common,

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the condition most frequently associated with abnormal uterine bleeding by both the layman and the physician is carcinoma of the uterus and cervix.

It is true that considerable advances have been made during the last few years in the methods of diagnosis of normal and pathologic changes in the pelvic organs of women in the menopause, but too much emphasis has been placed on these newer diagnostic procedures. To be specific, the vaginal smear has been considered by some as a definite test for the diagnosis of malignancy of the pelvic organs and many women consult us insisting on being given a test for cancer. Although the vaginal smear is a valuable auxiliary diagnostic measure, it should never be substituted for the time-honored and proved methods, such as careful history, examination with the vaginal speculum, cervical biopsy, and diagnostic curettage.

As soon as the cause has been determined, treatment should be instituted promptly. There is no one accepted method for the treatment of menopausal bleeding which should be employed to the exclusion of all others. The treatment selected should depend on the individual case.

The administration of hormones for the control of abnormal bleeding at, near, or after the menopause, is not only unnecessary but dangerous, because this delays the institution of proper treatment of premalignant and malignant conditions and creates a false sense of security. The value of hormones is even questionable in the functional type of bleeding associated with the menopause.

Since the introduction of radium in 1917,[1] and later roentgentherapy for the control of menopausal bleeding, too much emphasis has been placed on the use of these agents for this purpose. The mere control of menopausal bleeding is no insurance that the patient will have no recurrences and that a premalignant lesion will not progress to a malignancy later. This is an important consideration now when the life expectancy of women is almost 70 years, as these women still have twenty-five or thirty more postmenopausal years of life.

It is true that radiation is effective in controlling bleeding at any age but there are many contraindications to its use. It should never be administered to emotionally unstable women. Its use is contraindicated in women with extensive obstetrical injuries, lacerated and diseased cervices, prolapse of the uterus, large fibromas, or adnexal disease. It should likewise never be employed in women who have previously been subjected to extensive pelvic operations complaining of pelvic pain in addition to uterine bleeding.

There is no doubt that radiation is easy to administer, has a low morbidity and mortality, and eliminates the bleeding following treatment but it does not assure the patient that she will have no difficulties in the future. The danger of the development of a malignant condition in the uterus or cervix at a later date is ever present. The incidence of malignancy after radium therapy has been estimated as 0.5 per cent[2] but it is not known whether these patients were followed only a few years or for the rest of their lives. Cancer does develop in patients over 70 years of age and at this stage it is always difficult to treat.

The performance of many minor operative gynecologic procedures such as conization or surgical amputation of the cervix, suspension of the uterus : combination of the ovaries with or without salpingectomy often fails to eliminate the abnormal bleeding and in many instances does not correct pathologic conditions which eventually will require a more radical procedure. Therefore, in the management of patients with menopausal bleeding, I prefer total vaginal or abdominal hysterectomy with preservation of normal adnexa in patients who have not reached the age of a normal menopause. Before this procedure is performed on any patient, exactly what is going to be done should be explained to the patient in her own vocabulary. Many emotional conditions developing after this procedure are due to failure of the surgeon to explain to the patient exactly what he intended doing

and the significance of the procedure. The patient should be assured that removal of the uterus will not produce nervousness, hot flushes, irritability, insomnia, insanity, loss of sexual powers, or obesity. She should be informed that hysterectomy will eliminate not only the vaginal bleeding but also the future possibility of pelvic operations for pelvic malignancies. Careful attention to these details will insure a relieved and satisfied patient in the future and will abolish the possibility of the development of malignancy at a later date. The mortality rate of hysterectomy is no greater than the future danger of the development of genital malignancy if more conservative measures are used.

This does not mean that conservative measures have no place in the control of menopausal bleeding. There are many patients with normal pelvic organs in whom irregular menstrual flow can be controlled by various conservative measures such as office cauterization of the cervix, simple curettage, weight reduction, correction of dietary deficiencies, relief of anemia by transfusions, iron therapy, and, most important of all, control of emotional states by reassurance. The family physician can best accomplish this latter point by convincing the patient that there is no danger of the development of cancer and that the menopause is a natural phase of life which all women undergo.

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DISCUSSION

Dr. R. E. C. Miller (Alexandria): Dr. Tyrone has ably described the usual things that cause bleeding during the menopause. The thing that puzzles me, and I am sure puzzles you, is what to do for the patient, when all the laboratory procedures have come back negative, all physical examinations negative, and you feel you don't know where the bleding is coming from. Even your consultant says, "Well, I don't know where she's bleeding from." Now, I think that Dr. Tyrone has got the answer to it— A hysterectomy— a hysterectomy at this age—it is remarkable to me how many patients at this time don't know anything about their own anatomy, certainly very little about the physiology of the female organs. I know that many of you have had patients—intelligent patients—come in and say something is wrong "down there" and not know what is normal bleeding and what is abnormal bleeding. So many patients even today think that the menopause is a time for plenty of bleeding instead of spotting of bleeding. I have never found any adequate description of the function of the uterus other than the fact that it is a child-bearing organ, and so many patients at the menopause stage, when they stop bleeding, either by a natural means or surgical means, think they are then out of this world as far as they are concerned as an individual. Magazine articles are coming out all the time telling about the symptoms of the menopause. I believe that hysterectomy, either total hysterectomy or vaginal hysterectomy, properly done, will never have any effect as far as sexual relationships are concerned, and I still think in those cases where the diagnosis is not obvious that the solution is a hysterectomy.

Dr. Tyrone (In conclusion): I'd like to thank Dr. Miller for his very excellent discussion and remind you of the statement that he made that he has found no definite importance of the uterus other than for childbirth. I could go a little further than that and say that the uterus has three functions: (1) to menstruate; (2) to bear children; and (3) to develop malignancy later on.

Therefore, after the childbearing age has passed and menstrual irregularities, such as hypermenorrhea and polymenorrhea and metrorrhagia, develop, I would advise total hysterectomy with preservation of normal adnexa up to the age of 45 years. This especially holds true of the patient with such menstrual irregularities, who in addition has obstetrical injuries with varying degrees of prolapse and an infected and lacerated cervix and/or diseases of the fundus of the uterus, such as adenomyosis, fibroids, or fibrosis.

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ORAL ESTRUSOL THERAPY IN THE MENOPAUSE

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During the past few years there has been an increasing appreciation of the fact that a large psychic component is

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*Estrusol used in this study was furnished by courtesy of Carroll Dunham Smith Pharmacal Co., New Brunswick, N. J.

associated with the menopausal era and its complaints. Despite the number of subjective symptoms which are attributed to this psychic component, the striking symptoms of vasomotor instability, flashes, flushing, and sweating are attributable to estrogenic deficiency and are best controlled by estrogenic therapy. We have reduced the amount of estrogenic therapy utilized in the menopausal era in the past few years, and with the advent of effective oral estrogens have shifted emphasis from the use of hypodermically administered drugs to orally administered drugs. Because of the proved efficacy and relative cheapness of the synthetic estrogens we have also shifted to a considerable extent from the biologic to the synthetic estrogens. However, some 10 to 15 per cent of patients are intolerant to the synthetic estrogens. We have stressed the importance of reassurance, psychic therapy, and mild sedation, rather than the wholesale application of estrogenic therapy to every menopausal patient. Despite this fact there remain a large number of patients whose vasomotor symptoms are sufficiently severe to give them considerable disturbance, and it is chiefly in this group of patients that we have utilized estrogenic therapy.

For the present study we selected menopausal patients, who in addition to the various ailments of the menopausal era, have as an outstanding component of their syndrome the complaint of severe flashes and flushes. These patients were divided into three groups. One group was given a placebo, the tablet appearing exactly like the active estrogenic tablet. A second group was given sedation alone, and a third group was given estrusol orally.

The estrogenic activity of estrusol tablets is due principally to estradiol. The tablets that we used were assayed by the method of Kahn and Doisy and were found to contain approximately 10,000 International Units per tablet. These were administered in dosage of 1 tablet per day for fourteen days. The patients when first seen were interviewed and a complete history and physical examination obtained, together with such pertinent laboratory data considered necessary. Every attempt was made to rule out systemic diseases which may mimic symptoms of the menopause. The patients were then assigned to one of the three therapy groups in rotation.

Fifty patients were in the group receiving placebos, and at the end of a two week period 5 stated that they had complete or partial relief. The remainder complained of symptoms as severe or of greater severity than upon first being seen. In the second group, who received only simple sedation with phenobarbital grs. 1/4, three times a day, there were also 50 patients. At the end of a two week period 26 of these patients stated that they had marked relief of the symptoms that would be attributed to nervousness such as, insomnia, and irritability, but had obtained no relief from their vascular symptoms. Nine patients had partial relief from their symptoms other than the vascular ones, and the remainder had no improvement.

Of the 50 patients who were placed on estrusol therapy, 31 patients stated at the conclusion of the two week period, that they had complete relief from their flashing and flushing. Seven patients had partial relief, and the remainder had no relief. However, of the 31 patients who had relief of their vascular symptoms, 16 of them still complained of some degree of nervousness, irritability, and insomnia. These patients were placed on a combination of phenobarbital and estrusol, at a later date, and had complete relief of all symptoms.

During this initial trial period no patient gave evidence of any toxicity from estrusol therapy.

The groups were then continued on the same therapy for an additional two weeks, the results being approximately similar. In the first group 6 patients stated that they had some relief. In the second group 22 stated that they had considerable improvement, 12 had some improvement and the remainder had none. In the estrusol group, 30 had complete relief, 9 partial relief, the remainder no noticeable improvement.

After maintaining these patients on this

routine for a month the patients in the placebo group were transferred to one of the other groups and then continued in the survey as such. Of the other two groups, the ones who previously had sedation alone were given sedation (phenobarbital) and estrusol. The ones who had estrusol alone were given estrusol and phenobarbital. The combination of a simple sedative and the estrusol gave marked improvement in the majority of cases. Of the 100 cases so studied 73 had marked improvement, 64 of these stating that they had complete relief of their vascular symptoms. Thirteen patients had partial improvement of all symptoms, 9 of these having partial relief of their vascular symptoms. The remainder stated that they had no particular improvement.

From the observations of this preliminary study on an orally effective estrogen, estrusol (principally estradiol), we feel that this drug has no toxic effect and has a marked beneficial effect in the management of menopausal symptoms attributable to estrogenic deficiency. The study is being continued and a more complete survey will be published at a later date.

VAGINAL BLEEDING FROM THE USE OF POTASSIUM PERMANGANATE

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Recently two cases of severe vaginal bleeding due to the use of potassium permanganate were admitted to the Charity Hospital of New Orleans. Both were of sufficient severity to be admitted to the hospital for treatment because of the amount of blood lost. One of these cases will be described.

CASE REPORT

C. S. a colored female 19 years of age, was admitted to the Charity Hospital on July 7, 1945 with a chief complaint of vaginal bleeding. The patient stated that she began to bleed suddenly and profusely following a douche of potassium permanganate solution taken that morning. She stated that she habitually used "potash tablets" in preparing a douching solution, but denied that she had ever placed any undissolved tablets in the vagina. She estimated that she had lost a quart of blood before coming to the hospital.

The last regular menstrual period started on July 1, 1945 and the patient denied pregnancy or any attempt at abortion. On pelvic bimanual examination the uterus was found to be retrocessed, not enlarged, slightly boggy in consistency; the cervix was slightly softened but closed. There were no abnormal masses, tenderness, or fixation in the adnexal regions, and the uterus was freely movable. Speculum examination of the vagina and cervix revealed no active bleeding at the time of admission; however, on the right vaginal wall about midway between the introitus and the cervix an adherent black eschar was noted. In the center of this was a small adherent blood clot. There was also a small bleeding area just to the right of the cervix.

She was discharged on July 8, 1945 after receiving 500 cc. of blood. Final diagnosis: Chemical burn of the vagina and possible early pregnancy.

A search of Charity Hospital records for the past several years failed to reveal any similar cases. None were found in the emergency room records of this institution for the past three years.

A review of the literature produced only two references to vaginal burns from the use of potassium permanganate in this country. Both reports came from the Boston City Hospital; the first in 1941 by Shull,[1] and the second in early 1945 by McDonough.[2] Shull reported 17 cases occurring between the years of 1936 and 1940 and McDonough found that this series had increased to a total of 65 cases by the end of 1944 at this institution. They observed that in all their cases potassium permanganate tablets had been inserted into the vagina to produce "menstruation", although 5 of the 17 cases reported by Shull denied use of the tablets to produce abortion. However 15 of Shull's cases had amenorrhea of one day or longer; one of this group had inserted the tablet on the day of expected menses; one had a positive Friedman's test. The duration of the amenorrhea, in the cases reported by McDonough, was as long as six months.

These authors state that the cases presented all gave a uniform clinical picture, easily confused with threatened or incom-

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plete abortion. Three characteristics common to all were (1) painless, profuse vaginal bleeding; (2) a tightly closed cervical os; (3) a circumscribed, charred vaginal lesion which could be visualized easily by the use of a vaginal speculum. In 4 cases of McDonough's, in which speculum examination did not seem to be immediately indicated, a diagnosis of incomplete abortion was made because of the apparently open cervical os and because of a misleading history of having passed fetal tissue. The correct diagnosis was made only after the cervix was exposed under general anesthesia. McDonough further observed that the onset of bleeding in these cases usually occurred within two hours after the insertion of the tablet and persisted after removal of vaginal clots. Although the irregularity caused by the chemical burn can be usually felt on the cervix or vaginal mucosa, the routine use of a vaginal speculum in all cases of threatened or incomplete abortion is emphatically recommended by both authors.

As to treatment, 6 of Shull's cases required bed rest only; 9 required vaginal packing and 2 required suture of the lesion to stop active bleeding. In McDonough's series, 10 cases required from one to three mattress sutures to control bleeding from the eroded area, thirty-four were treated by firm vaginal packing for forty-eight hours and 12 cases were given treatment for shock including several transfusions.

Only 6 were successful in producing abortion, as evidenced by the recovery of fetal tissue, and only 1 had a vaginal vault adhesion secondary to the burn. No generalized toxic symptoms as a result of absorption of potassium permanganate were observed.

In view of the rarity of this lesion in the United States, it is interesting to note that it has been recognized for a number of years by Italian, Spanish, and French writers as a cause of vaginal bleeding. A total of ten references was found in the foreign literature, the majority coming from Italy. The earliest reference was by Valenzi,[3] and most recent by Taddei,[4] in 1934 and 1940, respectively. Folsome,[5] reviewed the paper of Taddei and pointed out that he described 2 cases in detail in which potassium permanganate had been used as an abortifacient and gave a complete review of the literature. He also summarized the pathology, symptomatology, diagnosis, clinical course, complications, and treatment. G. de Maria,[6] reported a case of "cicatrix of the uterine neck due to chemical caustics ($KMnO_4$) as a cause of dystocia". Two of the foreign authors refer to cases of grave vaginal hemorrhage caused by potassium permanganate used as a lavage, apparently in concentrated form, to produce abortion.[7, 8] Carteaud and Barowski,[9] report a case of "pseudo-chancre of the uterine cervix" caused by the insertion of this drug in tablet form.

In view of the extremely caustic local action of potassium permanganate in contrated form on the mucous membrane of the vagina, it is noteworthy that this drug swallowed accidently or for suicidal purposes, although common in occurrence, is rather innocuous. This is probably due to early and rapid vomiting and to dilution of the drug in the stomach contents, thereby preventing erosion and subsequent hemorrhage.[10]

COMMENT

Potassium permanganate should be considered as a cause of unusual vaginal hemorrhage. The use of the drug as an abortifacient is definitely popular at present in the area of Boston, as evidenced by the reports of Shull and McDonough, and seems to be increasing. Although no cases have been reported in other areas of the United States, the possibility of its use for this purpose should be kept in mind, and the fact that it can cause vaginal bleeding, closely simulating threatened or imcomplete abortion, should be remembered. Women should be cautioned to use the drug only in solution and in the proper dilution if used at all. Some women douche by inserting the end of the rubber tubing into the vagina without the tip and it is possible for a partially dissolved tablet to be deposited in the vagina.

CONCLUSIONS

1. A case of vaginal bleeding from the use of potassium permanganate is reported and the literature on this subject reviewed.

2. The need for recognition of this drug as a cause of vaginal bleeding, particularly during early pregnancy, is emphasized.

3. A speculum examination of the vagina and cervix should be made routinely in all cases of threatened or incomplete abortion.

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ADVANCED ABDOMINAL PREGNANCY

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NEW ORLEANS

In discussing the paper of Wilson[4] on advanced ectopic pregnancy, at the recent meeting of The American Gynecological Society, Campbell proposed the following question: "If one were to recognize a late abdominal pregnancy, unaccompanied by symptoms, in the event of the child being alive but of questionable viability, should such a case be treated as an emergency or would one be justified in postponing operation in the hope that by waiting one might obtain a viable baby?"

This question is a most interesting one, and all of us may at one time in our careers be faced with such a problem. I cannot definitely answer such a question, but if we recall some of the hazards facing both mother and infant, we should have a better understanding of the problem.

Advanced abdominal pregnancy is interesting from many viewpoints—etiology, diagnosis, treatment, and fetal survival. In a paper of this type which is limited as to time, it is not feasible to cover all the salient features of this condition. Consequently, I have chosen to discuss advanced pregnancy located extrauterinely as to diagnosis and as to the hazards faced by the mother and fetus.

DIAGNOSIS

For all practical purposes late abdominal pregnancy is always secondary to a tubal pregnancy although a few cases of apparent primary peritoneal implantations have been reported. Consequently, in the majority of cases a history of an episode simulating tubal rupture or abortion is obtained in the early months of pregnancy. The symptoms often are so slight as to be overlooked by the patient, and the findings so minimal as not to warrant active treatment.

Following this episode of tubal abortion or tubal rupture the fetus may survive and continue to grow, giving rise to the later signs and symptoms of an advanced extrauterine pregnancy.

The most prominent symptoms noted are persistent pelvic or abdominal pain, more severe than the usual complaints noted in the normal pregnant woman. There are also gastrointestinal disturbances, such as nausea and vomiting, or severe indigestion in the latter months of gestation. In the multiparous patient definite statements as to the location and character of fetal movements are suggestive. Fetal activity may be felt either very high or very low, and it may be markedly decreased or increased over that of former pregnancies.

A patient who gives a history of a possible early tubal abortion or rupture and who complains of the above symptoms in the latter months must be given a careful physical examination in order to rule out an extrauterine pregnancy.

The most characteristic physical findings are as follows: Upon abdominal examination the fetus is usually located high and in

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a transverse or oblique position. Fetal parts are easily palpable, and fetal heart tones are loud in character. The patient is usually sensitive to palpation. Definite failure to feel the round ligaments, of course, is pathognomonic of an extruterine gestation. Likewise failure to feel uterine contractions is suggestive.

Pelvic examination is important and must be done carefully in order to elicit supporting signs of an abdominal pregnancy. The cervix is usually not as soft as that of an intrauterine gestation and it is characteristically uneffaced and undilated. If it does admit a finger, no products of conception are felt in the uterine cavity. An abnormal position of the cervix is frequently noted. The uterus is not enlarged to the size compatible with the period of pregnancy and an extrauterine mass is palpable.

X-ray certainly is a useful procedure in diagnosing advanced extrauterine pregnancy.

HAZARDS TO THE MOTHER

There are two main hazards to the mother with an advanced ectopic gestation, namely, hemorrhage and peritonitis. In Cornell and Lash's[2] series of 236 cases three-fourths of the deaths were due to these two conditions. Generalized peritonitis accounted for the one death in Beacham's[1] 20 cases.

At any time placental detachment may occur and lead to massive intraperitoneal hemorrhage with a fatal termination unless immediate measures are employed to control the bleeding. On the other hand, fetal death with subsequent infection of the fetal sac may occur. The products of conception, lying in the abdominal cavity, are in intimate contact with the intestines and are easily infected from this source. Suppuration occurs, the sac ruptures, and generalized peritonitis results.

These two conditions, hemorrhage and peritonitis, are serious ones of course. Fortunately today we have at our disposal such great helps as blood, chemotherapeutics, and antibiotics, which have enabled us to reduce the number of deaths from these two hazards.

One cannot discuss the problem of late abdominal pregnancy without mentioning the management of the placenta. At the time of laparotomy it is essential to realize that this organ can be left without jeopardizing the life of the mother. Consequently, if the placenta is attached intimately to the intestines or other abdominal viscera, leave it alone. Fatal hemorrhage results from injudicious attempts to remove the placenta. If there is any doubt as to the possibility of removing this organ, then the best policy is hands off.

HAZARDS TO THE FETUS

Not only does the mother face certain dangers, but also the fetus is exposed to hazards from extrauterine pregnancies which have advanced to viability. We[3] have studied the fate of living babies from ectopic gestation. From this study we have concluded that only about one-fourth of all extrauterine pregnancies diagnosed after the fifth month will result in viable living babies. Approximately one third of these infants will have minor and major deformities, some of which are incompatible with life. These deformities are for the most part plastic in type and result from pressure phenomena. Some of these deformities may be corrected by orthopedic measures. About 50 per cent of these viable babies will survive eight days or more; while the others will have died in the neonatal period.

SUMMARY

The signs, symptoms, and physical findings of late abdominal pregnancy are discussed. Major maternal hazards in these cases are fatal hemorrhage and generalized peritonitis. About one fourth of all extrauterine pregnancies diagnosed after the fifth month will result in viable babies. One third of these babies will have plastic deformities. Fifty per cent will survive eight days or more.

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VALUE OF PROCTOSCOPIC EXAMINATION IN GENERAL PRACTICE*

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NEW ORLEANS

Probably no patients are more reluctant to seek medical assistance than the ones with anorectal complaints. These patients will usually take the advice of a friend or the neighborhood pharmacist for relief of rectal symptoms rather than consult a physician because of embarrassment, and frequently this results in delaying the diagnosis of a serious condition beyond the period when treatment can be effective. For this reason, the public should be made conscious of the dangers of procrastination in seeking medical aid for anorectal diseases merely because of a feeling of false modesty. However, the responsibility of early diagnosis of anorectal conditions is not entirely that of the patient. The general practitioner can detect many conditions in the stage when curable treatment can be instituted if he will take the time to obtain a careful history and make examination of the anus, rectum, and sigmoid a routine part of the general examination. The general practitioner may be inclined to omit examination of the rectum if the patient fails to mention symptoms referable to this organ. It should be borne in mind that many patients are extremely reluctant to volunteer information concerning bowel habits and anorectal sensations unless specifically questioned. Furthermore, the general practitioner should not let his personal distaste for performing a rectal examination interfere with its routine performance. Only in this way can many serious rectal conditions be detected before they become incurable.

This discussion will be confined to a few of the more common anorectal complaints encountered in general practice for which a proctoscopic examination is indicated. Among these are bleeding, rectal pain, change in bowel habits, masses in the perianal region, protrusions, and pruritus ani.

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BLEEDING

Bleeding is one of the most important signs of rectal disease and should always be regarded with grave concern, for although the cause may be trivial and the bleeding transient, hemorrhage in this region may be a threat to life itself. If all cases of proctorrhagia were considered by the patient as well as by the physician to be due to cancer until proved otherwise, there would be a considerable decrease in the present delay in early and correct diagnosis of rectal malignancies.

The duration of bleeding, whether intermittent or constant, and the color, whether bright red, dark red, or tarry black, are important clues to diagnosis. The relation of bleeding to bowel movement should also be determined, that is, whether it oozes, drops, streaks the outside of the stool, or is mixed with the stool. The dripping of blood after a bowel movement or the unexpected soiling by blood is usually due to a lesion which is below the grasp of the external sphincteric muscle. Associated anal discomfort suggests a lesion distal to the anal cutaneous line or the dentate line, since this represents the upper limit of sensory innervation. Bright red blood usually comes from the rectum and anal canal, and dark red blood signifies that it has remained within the intestine for some time or that it arose in the gastrointestinal tract. In general, it may be assumed that bright red blood comes from a lesion distal to the sigmoid, whereas dark blood suggests a lesion proximal to the rectosigmoid. However, there are exceptions to this rule. For example, profuse hemorrhage may result from a duodenal ulcer with rapid passage of this blood through the intestinal tract and its appearance through the anus while it is still bright red. On the other hand, the blood from an internal hemorrhoid may be passed as a dark clot from the rectal ampulla many hours after bleeding occurred.

Every patient with rectal or anal bleeding should have the advantage of digital,

anoscopic, and proctoscopic examinations. If hemorrhoids are noted, they should never be accepted as the cause of bleeding until polyps, or ulcerative or inflammatory diseases of the bowel have been eliminated by adequate examination. Polyps are frequently the cause of bleeding from the rectum and a high percentage of these lesions are precancerous. For this reason, it is imperative that they be discovered and eliminated before they become cancerous. Next to the skin, the rectum and colon are the most frequent sites of carcinoma in the body. From 70 to 75 per cent of cases of carcinoma of the entire large bowel are within the reach of the sigmoidoscope. Too often the physician has sent away the patient who complained of bleeding from the rectum with a box of supositories or a prescription for them and the assurance that these will help him. In my opinion, suppositories are not only useless but dangerous. They do not cure any lesions. Occasionally they may relieve pain but this benefit is counteracted by the danger of lulling the patient into a sense of false security. The medication in supositories does not reach the lesion. If the patient is ambulatory, the melted cocoa butter, which is the chief constituent of any suppository, seeps through the anal canal to soil the patient's clothes. If the patient is in bed, the melted suppository follows the law of gravity and runs into the hollow of the sacrum away from the anal canal where are located most of the lesions for which suppositories are given. The medication is therefore rarely ever in contact with the lesion for a sufficient length of time for even palliative value.

If digital, anoscopic, and sigmoidoscopic examinations do not reveal the cause of the bleeding, a roentgenogram of the colon with barium enema should be obtained. Roentgenography with the instillation of a contrast medium is essential for the location of the majority of polyps of the colon. If this does not reveal the cause of bleeding, the patient should be repeatedly examined until the source has been located.

RECTAL PAIN

Many patients will complain of "rectal" pain which actually is pain of anal origin. This is probably the most frequent proctologic symptom which causes the patient to seek medical aid. Numerous lesions, such as uncomplicated hemorrhoids, and benign and malignant growths, do not give rise to pain but may cause pressure. Thrombosed or strangulated hemorrhoids, or a foreign body in a crypt may be the cause of pain, but more frequently some infection in or near the anal canal, such as fissure in ano, cryptitis, abscess formation or fistula in ano, is the usual cause. The character of the pain at the time of onset with relation to bowel movements often gives diagnostic clues. Sharp, acute, cutting, burning, tearing or stinging pain, spasmodic in character, coming on with or following passage of the stool, always points to a lesion in the anal canal, such as, a fissure in ano or chronic ulcer. The pain of cryptitis is usually sharp and lancinating. Pain of a throbbing or constant character usually indicates an ischiorectal, perirectal, or perianal abscess. This pain is ordinarily not affected by evacuation. Extension of infection from the anal crypt may produce a chronic fissure in ano, peri-anal abscess, or a fistula in ano. Finally, recognition of any one of these lesions may be possible by digital and anoscopic examination.

CHANGE IN BOWEL HABITS

The number and character of stools passed during the twenty-four hour period represent the individual daily bowel habit. It is generally considered normal for a person to have one evacuation of the bowels daily. However, it is not unusual to find perfectly well people who have a movement every other day or even every third day. Likewise, persons can be considered normal who have two or three stools daily and also there are those who never have a formed stool. A change in the bowel habit or character of the stool is considered by some as presumptive evidence of malignancy of the colon until carcinoma has been ruled out by adequate examination. A definite alteration in bowel habits should always make one suspicious of disease in the colon or rectum.

At the first interview the patient should

be questioned as to the presence of constipation or diarrhea, whether there is pain or blood, whether the stool is hard or soft, its shape, such as pencil stool or ribbon stool, whether the stool is covered with mucus, blood, or pus, and whether the action is complete and satisfying. It is important to know the patient's age, occupational habits, and environment, and whether he uses cathartics or enemas. Stools mixed with blood and purulent debris are seen in cases of malignancy, nonspecific ulcerative colitis, and other types of ulcerative colitis and proctitis.

PROTRUSIONS

Although the most common type of rectal protrusion is some variety of hemorrhoids, prolapse of the rectal mucosa occurs much oftener than is usually recognized. There are two types: mucosal prolapse, which is the common type, and complete prolapse or protrusion of all layers of the rectum. Protrusions of the anal papillae and carcinoma must also be considered in the differential diagnosis. The patient should be asked if the protrusion first appeared following a bowel movement, if straining was necessary to produce it, if it appeared spontaneously, and if it could be replaced. The number of protrusions is also significant. If bleeding occurs at the time the protrusion appears, and if the protrusion remains outside the anal sphincter, a polypoid rectal growth should be suspected. Polyps may be attached by a long pedicle or they may be sessile and protrude with a fold of mucous membrane. In children, the history of protruding, bleeding hemorrhoids should lead one to suspect the presence of one or more polyps.

ANAL AND PERI-ANAL MASSES

Masses in the perianal region may be single or multiple, smooth or nodular, rough, hard, or fluctuating, and are usually caused by inflammatory processes. An elevation at one or the other side of the anus accompanied by throbbing pain, elevation of temperature, and tenderness is usually a manifestation of an ischiorectal or peri-anal abscess. It should not be difficult to diagnose these masses because of the accessibility of this part to inspection and palpation. A hard mass appearing suddenly at the anal verge often accompanied by intense throbbing pain is usually due to an acute thrombotic external hemorrhoid. Single or multiple, firm, small, nodular elevations in the perianal space are not infrequently condylomas acuminatum or granulomas. Smooth, rounded, nontender elevations are usually lipomas or sebaceous cysts. Elevation of the peri-anal region from which a purulent discharge exudes is usually the external opening of a fistula in ano. These may be single or multiple. Skin tags are soft; they are of frequent occurrence and usually of long duration. A sentinal "pile" is an acute inflammatory elevation of skin and granulation tissue at the distal end of a fissure in ano. It must be remembered that epitheliomas and, in rare instances, tuberculosis and syphilis, may occur in this region.

PRURITUS ANI

Itching in the peri-anal region is probably the most annoying symptom excluding pain. The degree of itching varies greatly. A simple, transitory type is usually due to unhygienic habits and must not be confused with real pruritis ani. The aggravating and demoralizing effect of anal pruritus is characteristic of the pruritic syndrome. Itching may be of such intensity as to interfere seriously with the patient's work and sleep. Itching as the predominant symptom, in my experience, has usually resulted from some local lesion of the anorectal region. It should be kept in mind that constitutional diseases, such as allergy, diabetes, dysentery, and acidosis, may predispose to itching in any part of the body. Of utmost importance is determination of the etiology of the itching, if possible.

All local pathologic conditions, such as internal and external hemorrhoids, hypertrophied prolapsing anal papillae, fissure in ano or fistula, should be eliminated before any attack on the pruritus itself is made. The cause of itching may be a fungous infection of the peri-anal skin or an id reaction to a distal focus or fungous infection.

After every effort has been made to determine the cause of itching and to elimi-

nate the local pathologic condition, there will remain some cases in which a diagnosis cannot be made. Most of these, I believe, are of neurogenic origin.

SUMMARY

In summary, it might be said that if a patient gives any evidence of symptoms referable to the anus, rectum, or colon, a complete history and physical examination including examination of the anus, rectum, and colon should be done to establish a correct diagnosis as a requisite to proper treatment. It has been estimated that proctosigmoidoscopic examination will indicate or assist in indicating the diagnosis in one of every seven patients.

MECONIUM ILEUS

WALLACE SAKO, M. D.

NEW ORLEANS

The relationship of meconium ileus to pancreatic achylia was first indicated by Landsteiner[1] in 1905. Since then various investigators[2, 8] have shown their etiological relationship. Sidney Farber[4, 8] reported that in 18 cases coming to autopsy an obstructive lesion could be demonstrated in the pancreas in every instance. The purpose of this paper is to present 6 cases of true meconium ileus seen by the author in the past twelve years and to discuss briefly the principal features of the disease and its treatment.

Meconium ileus should be differentiated from inspissated meconium which arises from partial or complete intestinal obstruction such as volvulus or obstruction at the ileocecal valve. In the latter condition, the character of the meconium is normal, and therefore, when the obstruction is relieved, the meconium is readily evacuated. On the other hand, the basis of true meconium ileus is pancreatic achylia. The absence of pancreatic secretions results in the production of abnormal meconium largely in the ileum and jejenum. The meconium is thick, sticky, and mucilaginous, so that normal evacuation from the gastrointestinal tract is impossible. Thus obstruction results. The ileum and jejunum are dilated tremendously, to such an extent that they are far larger than the caliber of the large intestines. Sometimes dilatation of the ileum and jejunum causes necrosis of the intestinal wall resulting in rupture and release of its contents into the free peritoneal cavity. This happened in Case 6.

The pathological lesion in the pancreas responsible for meconium ileus has been described by Kornblith and Otani,[2] Hurwitt and Arnheim,[3] and by Farber.[4] The obstruction in the pancreas may be one of two kinds or both:

1. Stenosis or atresia of the pancreatic ducts.

2. Intrinsic obstruction with inspissation of the abnormal secretions in the acini, dilatation of the acini, atrophy, dilatation of the smaller pancreatic ducts, and finally fibrosis of the pancreas.

At times the pathology in the pancreas may be localized; in other instances it may be a generalized process involving all the secretin producing structures of the body, particularly the tracheal and bronchial secretory apparatus leading to chronic pneumonia, or the secretory structures of the liver with resultant cirrhosis.

DISCUSSION

If pancreatic achylia occurs at the time of birth, meconium ileus invariably results. If it occurs after the neonatal period but under one year of age, the clinical picture produced is that of chronic fibrosis of the pancreas with malnutrition, chronic pulmonary pathology, or cirrhosis of the liver. If it occurs after the first year, the clinical picture produced closely resembles that of idiopathic celiac disease. The pathogenesis of the three clinical conditions is therefore dependent on the time at which the pancreatic achylia occurs.

Meconium ileus is invariably fatal. In cases 5 and 6 the obstruction was completely relieved by irrigation with normal saline and 10 per cent pancreatic extract but the patients succumbed in sixty-one days and

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TABLE 1.

SUMMARY OF 6 CASES OF MECONIUM ILEUS.

No.	Birth Weight	Sex	Age at Diagnosis	Tryptic Activity	Surgical Treatment	Medical Treatment	Age at Death	Autopsy Findings
1.	6 lb. 4 oz.	Male	4 days	Not done	None	None	6 days	Atresia of pancreatic ducts.
2.	8 lb. 1 oz.	Male	6 days	Not done	None	None	10 days	Stenosis & atresia of pancreatic ducts.
3.	7 lb. 12 oz.	Female	2 days	Not done	None	None	7 days	Stenosis & atresia of pancreatic ducts.
4.	7 lb. 6 oz.	Male	Birth	Not done	Laparotomy, ileostomy and washing with saline	None	4 days	Stenosis & atresia of pancreatic ducts.
5.	6 lb. 6 oz.	Male	Birth	Absent	Laparotomy, ileostomy & irrigation with 10% pancreatic extract	Pancreatin Casein hydrolysate	61 days	Stenosis & atresia. Intrinsic obstruction.
6.	7 lb. 4 oz.	Male	Birth	Absent	Laparotomy, mobilization of rupture in ileum to abd. wall	Pancreatin Casein hydrolysate vitamins	52 days	Stenosis & atresia. Rupture in terminal ileum.

fifty-two days, respectively, from malnutrition and bronchopneumonia. Farber[5, 8] has shown that the abnormal meconium can be liquefied by the addition of pancreatin suspended in normal saline in a concentration of 1 to 10 per cent. In a concentration of 1 per cent the meconium is liquefied in from two to four hours, but when the concentration is 5 or 10 per cent, it is liquefied in one to two hours. On this basis it has been recommended that the meconium ileus can best be relieved by an ileostomy and injection of pancreatic extract in a concentration 1 to 10 per cent. By this procedure the obstruction can be relieved, but since the fundamental difficulty is pancreatic achylia, the patient ultimately succumbs.

In 2 of our cases (cases 5 and 6) analysis of the duodenum contents failed to reveal any evidence of tryptic activity. This was also reported by Farber.

After the intestinal obstruction is relieved surgically, there still remains the problem of supplying the absent pancreatic secretion and maintaining the nutrition of the patient. The management then should proceed along two lines:

1. Dietary regime, giving the infant foods which can be absorbed and readily utilized. When dogs are subjected to experimental pancreatic achylia by tying off the ducts, their ability to handle the primary foods will be poorest with protein; next, the fats, and last with the carbohydrates. Shohl has shown that patients with pancreatic fibrosis will have large bulky abnormal stools, which may assume as much as 25 per cent of the total body weight. These bulky fecal materials contain from four to five times the normal excretions of nitrogen and from three to five times the amount of fat which is normally excreted.

Feeding the patients nitrogen containing foods but no native protein did not diminish the amount of nitrogen or the character of the stool. The administration of pancreatic extract caused a diminution in the bulk of the stool and less excretion of nitrogen, but did not affect the excretion of the fats. This is readily understood since most of the pancreatic extracts put out today have high proteolytic activity but are low in lipolytic activity. Farber has shown that the bulk of the stools and the excretion of fat and nitrogen can be reduced to practically normal if the patient is fed exclusively on casein hydrolysate, condensed milk, and water soluble vitamins.

2. Just as in diabetes, hormone replacement is essential, so in this condition the administration of pancreatin is indicated.

SUMMARY

Six cases of meconium ileus are briefly reported. The pathological picture, surgical and medical management are discussed. Notable progress has been made in relieving the obstructive meconium from the gastrointestinal tract, but at present prognosis is hopeless until products are available which will completely replace the external secretions of the pancreas.

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THE TREATMENT OF DELIRIUM TREMENS

JAMES A. WALLACE, M. D.*

MEMPHIS, TENN.

Delirium tremens is the most frequent of the several types of psychoses due to alcohol. Although the exact etiological factor in the production of this disease is not known, some investigators feel that a deficiency of vitamin B is responsible. It is certainly a rarity to see a chronic alcoholic who uses anything like an adequate diet. Since the routine use of large doses of vitamin B has been employed in the treatment of alcoholics, a definite decrease in the incidence of delirium tremens has been noted.

The psychosis usually occurs in chronic alcoholics after prolonged periods of excessive drinking and poor intake of food. The sudden withdrawal of alcohol as the cause of the condition has been stressed in the past but is probably the apparent cause rather than the real cause. In the prodromal stage the patient is tremulous, sleepless, may complain of nausea and vomiting, and therefore, may have a distaste for alcohol as well as for food. Apparently infections or fractures may precipitate a delirium. An example of such a case was a 55 year old man who had used a quart of whiskey a day for about four years. He was transferred to the sanitarium from a general hospital where he had developed severe delirium tremens shortly after a cast was applied to a fractured femur.

In the typical case the patient appears frightened or even terrified. Generally he is agitated and reacts to stimuli in his environment. He may be confused and disoriented for time and place. The vivid visual hallucinations are among the outstanding mental symptoms. According to the usual description, rats, snakes, and various other animals are usually seen, but in our experience, the hallucinations are more often of human beings. One patient stated that he had just seen and talked with his family doctor. Another patient stomped on imaginary rats in the corner in his room. A 25 year old boy, at the onset of his delirium, was observed to carefully place newspapers in the chair before being seated, "because there's a pool of water in it." Another patient was amused and smiled frequently at an imaginary circus performance on the front lawn in which the performers were "little men and little animals."

Visual illusions may be present in which certain objects seen by the patient become

From the Wallace Sanitarium, Memphis, Tenn.

animate beings that threaten his safety. Tactile hallucinations are sometimes present; the patient feels insects crawling on his skin and may go through the motion of brushing them off.

The course of delirium tremens is from a few hours to several days, depending on how soon adequate treatment measures are instituted. The mortality rate, as reported by various clinics and hospitals, varies from 4 to 15 per cent. Death usually results from heart failure or pneumonia. A rare case may continue into a Korsakow's psychosis, which is a prolonged illness characterized by disorientation, amnesia with confabulation, and peripheral neuritis.

The chief problem in treatment is to secure adequate relaxation, sleep, and fluid intake, before the patient dies from heart failure. Alcohol should be discontinued at once. If possible, restraint should be avoided as the patient may die from exhaustion if struggling under various mechanical devices. Paraldehyde in 3 to 4 dram doses is the sedative of choice and is better tolerated than are other sedative drugs. Morphine, because of its depressant action, is contraindicated. The continuous bath is useful as a sedative measure. At this sanitarium the delirious alcoholic is routinely started on digitalis. A valuable aid in the treatment is the intravenous injection of 100 cc. of 50 per cent glucose with 25 units of insulin and 100 mgm. of thiamine chloride. This glucose-insulin-vitamin combination has been found to abort some attacks in the prodromal period and to terminate others in the early stages. Fluid intake must be maintained at an adequate level by either the oral or intravenous route. Saline catharsis should be used in order to promote proper elimination. We have seen no particular benefit from spinal fluid drainage as recommended by some investigators. Needless to say, constant nursing care is absolutely essential.

The usual termination of the psychosis occurs when the patient is able to sleep a few hours. The sooner sleep is brought about by the above treatment methods, the sooner will recovery take place. After recovery from the acute psychosis the patient should be maintained on large doses of vitamin B and on a nutritious diet.

The patient with delirium tremens is an emergency medical problem and is in need of immediate hospitalization and medical care.

SUMMARY

1. A description of the symptoms of delirium tremens has been given.
2. The routine treatment of such cases at the Wallace Sanitarium is described.

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ACUTE EYE DISORDERS AS SEEN IN GENERAL PRACTICE*

A. PENN CRAIN, JR., M. D.

SHREVEPORT

This paper will not interest eye specialists. It is designed primarily as an aid and a guide to the physician engaged in general practice who occasionally is called upon to treat an acute eye, and as it is impossible to give a detailed description of all the conditions one may encounter, I propose to discuss only the most serious.

CONJUNCTIVITIS

The most common cause of red eyes is conjunctivitis of one form or another. Some may be dismissed with little treatment while others are serious and must be watched closely.

Many texts group the types of conjunctivitis as: (1) catarrhal, (2) mucopurulent, and (3) purulent. I have grouped the catarrhal and mucopurulent together because the two conditions are often identical. Indeed, the mildest catarrhal conjunctivitis can become the most purulent if the resistance of the body is lowered or if the eye is badly treated.

The usual acute catarrhal or mucopurulent conjunctivitis is caused by a number of organisms, notably the *Kochs-Weeks bacillus, Morax-Axenfeld bacillus, staphylococcus aureus,* and *pneumococci.* This type is also found in association with some

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of the systemic virus conditions such as measles.

Characteristic findings are fiery red edematous conjunctiva, all the conjunctival vessels being injected except the circumcorneal zone in milder cases. At times there is even swelling of the palpebral conjunctiva. Mucopurulent material may be scanty or fairly profuse and when seen is found in the fornices and on the lid margins.

At first the discharge is mucoid but soon becomes mucopurulent. It reaches its height in three to four days, then tends to become chronic if untreated. Subjective symptoms consist of the sensation of a foreign body in the eyes, burning, itching, photophobia, lacrimation, and the lids are usually matted together in the mornings. Although diagnosis is usually simple, some cases of conjunctivitis are mistaken for iritis or vice versa, so that it is best to examine each case with magnification. The pneumococcal conjunctivitis, though clinically indistinguishable from other forms of acute conjunctivitis, shows distinct tendencies which should be borne in mind since this type is more prone to cause hypopyon ulcer. There is usually more edema of the conjunctiva and small ecchymoses are common. A membranous film occasionally forms and this type may be complicated by an iritis.

Treatment of this usually consist of washing the lids free from all secretion two or three times daily and application of sulfathiazole ointment, or sulfadiazine ointment, in the conjunctival sac twice daily, associated with a solution of 6 to 8 per cent sodium sulfadiazine drops flushed through both eyes. Dark goggles will relieve much of the photophobia. We do not use penicillin either in the form of drops or ointment because so often it causes a reaction in the lids. The lids become red, swollen, and tender, and may be moist. The *Kochs-Weeks* type (pink eye) deserves mention because of its extremely contagious nature.

PURULENT CONJUNCTIVITIS

Purulent conjunctivitis is characterized by copious yellow discharge and swelling of the lids and conjunctivitis. Usually there is fever and rather marked malaise. The cornea is involved in nearly 100 per cent of the cases that are not treated and may be severe enough to cause blindness. The disease is more serious in adults than in children and is nearly always due to the gonococcus, B. coli, or streptococci infections.

Streptococcal infections are even more virulent than gonorrhea because of corneal damage. Treatment for the condition is drastic. In spite of possible reactions, I use penicillin locally and intramuscularly. The local drops contain about 1500 units per cc. A heavier concentration can be used if desired along with 8 per cent sodium sulfadiazine drops altering the solution every hour. The eye must be kept clean and the patient isolated. If corneal ulceration occurs, atropine 1 per cent, three times daily, is used along with fever therapy in adults. Fortunately, true purulent conjunctivitis is rather rare.

Needless to say, when at all possible, in an acute conjunctivitis a smear or epithelial scraping of the conjunctiva should be examined because in the very early stages it is frequently difficult to differentiate the acute catarrhal or mucopurulent conjunctivitis from the frank purulent types. This promotes an early diagnosis, and therefore, treatment is much more effective.

As conditions affecting the cornea, anterior chamber, iris, or ciliary body usually in some way affect the other structures they should be considered together.

Probably the second most common cause of acute eyes is neglected corneal foreign bodies, especially if these are iron or steel. These foreign bodies may cause few symptoms at first, but almost invariably they will set up enough irritation in the anterior segment of the eye to cause intense pain, marked conjunctival redness, lacrimation, and photophobia. This then becomes the picture of an iridocyclitis associated with an area of keratitis about the foreign body. Naturally any foreign body on the cornea should be removed as quickly as possible. These frequently leave a little rust ring

which can be more easily removed in a day or two.

Any penetrating injury should be treated as an acute eye as these injuries, especially if the injured eye becomes inflamed, may cause sympathetic disease in the opposite eye. Sympathetic ophthalmia, when it occurs, always follows penetrating injuries.

Corneal ulceration from causes other than foreign bodies produces acutely inflamed eyes. The most common is the marginal type. These are usually catarrhal in nature and found in debilitated persons. They are a rather common complication of acute catarrhal conjunctivitis. They begin as minute, punctate, discrete, and superficial grayish infiltrates of the cornea at the limbus. Soon the infiltrates become ulcers. All corneal ulcers cause some degree of deep conjunctival injection. I like to cauterize these ulcers with tincture iodine and precipitate the iodine with cocaine. It is thought that it does as well and causes less scarring, while it is also less dangerous to use than carbolic or trichloracetic acid.

It is important in all cases to test corneal sensitivity with a small wisp of cotton as occasionally an ulceration which does not respond to treatment will be found to be due to loss of corneal sensitivity. This is the neuroparalytic keratitis sometimes seen, and is due to disturbances of the trigeminal nerve which supplies the cornea. These cases are marked by extreme chronicity and require treatment over long periods of time.

In general, the procedure to be followed after diagnosis of corneal ulceration is to treat the ulcer to prevent spread, by cauterizing with actual cautery, iodine, trichloracetic or carbolic acid. The extent of ulceration can be determined by instilling one drop of 1 or 2 per cent flouroscein, or 1 per cent mercurochrome, in the eye and after a moment or two wash it out with water or saline. This shows any break in the continuity of the epithelium as a green area. If there is any doubt as to how to treat the ulcer a standard text should be consulted or the case referred to an eye specialist as these ulcers can, and sometimes do, destroy the eye.

UVEITIS

Inflammations of the iris and ciliary body constitutes a good percentage of the patients seen in my office. A strict iritis or cyclitis by itself is pretty rare and the inflammation of one is almost always associated with inflammation of the other so that the condition is really an anterior uveitis or iridocyclitis.

In these cases the pupil becomes contracted and immobile and if the posterior surface of the cornea is viewed with slight magnification, minute pigmented bodies are found. They are the K. P.'s or keratitic precipitates. The iris becomes bound to the lens by fibrinous adhesions and these synechia can be quite troublesome. If the iris is bound to the pupil in the whole circumference of the pupil, the flow of fluid from the posterior to anterior chamber is obstructed. This causes the iris to be ballooned out making the anterior chamber very shallow. Also, the fluid in the anterior chamber which has become filled with cells and fibrinous material causes a blockage of the filtration angle so that the aqueous cannot escape freely from the anterior chamber and the tension rises accordingly.

In most acute cases there is an intense ciliary blush associated with deep conjunctival injection, chemosis of the conjunctiva, and even swelling of the upper lid. In addition to severe local pain and radiating neuralgia there is increased tenderness in the ciliary region. The diminution of vision caused by the haziness of the media may be accentuated in some cases by optic neuritis or edema of the macula. This condition is serious. Changes occuring during its courses are often permanent. Therefore, prompt diagnosis and treatment is essential. Iridocyclitis is caused by injuries to the eye and by foci of infection in other parts of the body. For those cases occuring spontaneously a thorough and diligent search should be instituted for the focus that is causing it.

Fever therapy in the form of boiled milk or typhoid antigen should be started. After the active fever stage caused by the foreign

protein, salicylates can be used. Many use salicylates routinely and it has been adequately proved that salicylates do have a beneficial effect on these so-called spontaneous cases. I like to prescribe salicylates as the condition is cooling off, reserving the fever therapy, full atropinization, and hot compresses, to the acute stage. The intra-occular tension should be checked, bearing in mind that one may mistake an acute glaucoma for an acute iridocyclitis if care is not used in examining the eye. If one is sure that the condition is an iridocyclitis, even though the intra-occular tension is raised, atropine is to be prescribed.

GLAUCOMA

In acute glaucoma, however, atropine is positively contra-indicated as atropine cannot be counteracted in the eyes and it will increase the severity of the glaucoma and cause loss of the eye. Atropine should always be prescribed with the greatest of caution.

Acute glaucoma is characterized by the intense redness, steamy cornea, and cloudy anterior chamber that marks iridocyclitis. However, the pain is much more severe. Further characteristics are that the eye is stony hard, and all vessels, superficial and deep, are injected. The pupil is often a guide to diagnosis and in these cases is widely dilated and greenish in color. Vision is rapidly lost. Every effort is made to contract the pupil so that more space is made at the filtration angle. Blind eyes with acute glaucoma often have to be enucleated to relieve pain.

When suppurative endophthalmitis has progressed so that all the coats of the eye are involved in purulent inflammation, panophthalmitis is the result. The lids are red and edematous, the bulbar conjunctiva is swollen, the eyeball is proptosed, and there is severe pain. Pus obliterates the anterior chamber and vitreous so that the whole anterior chamber appears yellow. If the panophthalmitis follows a perforating injury the symptoms are less severe as there is more drainage. Unless these eyes are eviscerated, the globe frequently ruptures, the eye becomes shrunken and phthisis bulbi results.

PURPURA PRESUMABLY DUE TO HOUSE DUST

CASE REPORT

B. G. EFRON, M. D.

NEW ORLEANS

W. R., age 6, referred by Dr. Herbert Rothschild, was first seen by me on September 30, 1946. The diagnosis was nonthrombocytic purpura.

History: Since the age of 7 months, the boy had repeated ecchymoses and hemarthrosis with other related and minor hemorrhagic manifestations occurring irregularly at about two month intervals and apparently having no relation to season, diet, or environment. For several months prior to the time I saw him, it seemed as though these hemorrhagic episodes were associated with colds. The family history was negative for allergic or hemorrhagic disease.

The laboratory data was as follows:

	1/6/44	1/26/44	2/3/44	2/8/44
Bleeding time	19' 29"	4' 43"		4' 10"
Coagulation time	7' 13"	3' 52"		3'
Reticulocytes	0.5%			0.5%
Platelets	683,680			385,480
Hematocrit	32			
R. B. C.	3,8400,000			4,190,000
Hemoglobin	69%			
Color Index	.9			
W. B. C.	12,200			
Neutrophiles	69%			
Lymphocytes	29%			
Monocytes	2%			
Plasma proteins				

Total	6.984	per 100 c.c.
Albumin	4.01	" " "
Globulin	2.974	" " "
Fibrinogen	.515	" " "

Clot retraction complete in 6 hours
Tourniquet test negative

Transfusions had been given about every month since early in February 1944. With several of these, there were marked urticarial reactions.

From the standpoint of allergy, the his-

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tory was that the boy sneezed a great deal, had a postnasal drip, especially at night, and during cool weather his nose was affected by the slightest change in weather. "Allergic salute" was present. Dusts induced sneezing.

Skin Tests (Scratch): *Showed definite* moderate to large reactions with house dust. Slight reactions were obtained for horse and dog dander.

Therapy: Allergen avoidance for reacting substances was recommended, and desensitation with house dust antigen was instituted Oct. 29, 1946. On Nov. 16, 1946, a transfusion was necessary, another on Dec. 28, 1946, and one on Feb. 22, 1947, hemorrhages having recurred. Since Feb. 22, 1947, with continued desensitization, no transfusions have been necessary, although on two occasions, Oct. 18, 1947 and Jan. 17, 1948, mild joint hemorrhages did occur.

SUMMARY

A case of purpura of the nonthrombocytic type is presented that is apparently due to house dust.

Desensitization with house dust antigen successfully controlled the symptoms.

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THE POSSIBILITY OF A PROVOCATIVE TEST IN ALLERGY*

CASE REPORT

STANLEY COHEN, M. D.

NEW ORLEANS

The problem of the young asthmatic with negative skin tests is not an uncommon one. These patients have all the criteria of allergic respiratory disease due to extrinsic sensitizing agents, but fail to produce skin tests to the offenders which would be anticipated from their history. In my experience the majority of these patients are infants or young children.

Where the disease is of no great severity, it has been my policy to advocate symptomatic management rather than empiric desensitization.

I was quite surprised to note the appearance of skin tests at about the third month of empiric desensitization in the following cases.

S. M. age nine, began to have asthma at the age of five years. At that time he lived in Chicago. He was seen by a well known allergist there, reported to be skin test negative and his parents were advised to have him treated with a vaccine. This was never done. He had several attacks of asthma between then and the time I saw him, including two attacks of status asthmaticus. The majority of these attacks occurred in the fall and spring and began at night. I saw him first in the spring of 1946 in the hospital in severe status. The same thing occurred in the fall of 1946. After two attacks of status, I felt that empiricism was justified, and proceeded to treat him as a house dust problem. I found him to be skin test negative twice, the last time just before beginning treatment. I was very surprised during the second month of his injections to notice that he was getting whealing reactions at the site of injection. I therefore skin tested him and found that he had developed a moderately positive scratch test to purified house dust. He has subsequently sustained two constitutional reactions occurring about fifteen minutes after an injection. His positive skin test persists.

Since then I have noticed the same phenomenon to occur in two other children. They likewise developed positive scratch tests around the second or third month of desensitization. One is a child of two; the other, a child of seven. The former had asthma for one year; the latter for three.

It is interesting to speculate regarding the mechanism of this response. I believe we can dismiss the possibility that these individuals were actually sensitized to house dust artificially. In so far as I know this has never been reported, and if it did occur, I should believe it would take longer with such a poor antigen.

We have all had the experience of inadvertantly increasing the immunological sensitivity of a patient. I studied the records of three patients in whom after a constitutional reaction I was forced to drop back in the schedule to a dose which had been passed without reaction. In two of these patients this had happened about the third month; in the other about six months.

*Read at the Sixty-eighth Annual Meeting of the Louisiana State Medical Society, Monroe, April 12-14, 1948.

There was no doubt that the immunological sensitivity of these patients was increased by treatment instead of decreased. This of course had no parallel in their clinical progress.

In 1940, Sherman, Stull and Cooke* reported that there was a definite increase in circulating reagin in some treated patients. Four patients whose sera were titrated by the dilution test manifested this increase at two or three months of treatment. With further treatment these cases showed a drop in reagin so that at the end of two to five years most cases showed less circulating reagin than before treatment.

If an increase in circulating reagin is produced in the first few months of treatment, then perhaps empiric treatment may be justified as a provocative measure in patients whose pretreatment circulating reagin is below the threshold necessary to produce positive skin tests.

*Sherman, W. B., Stull, A., and Cooke, R. A. *Serologic changes in hay fever cases treated over a period of years*, J. Allergy: 2:225, 1940.

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SUBACUTE DISSEMINATED LUPUS ERYTHEMATOSUS

REPORT OF A CASE TREATED WITH PARA-AMINOBENZOIC ACID

DAVID F. BRADLEY, M. D.

NEW ORLEANS

Lupus erythematosus is still included among that large group of diseases of unknown etiology.[1] Because of this, the treatment of lupus erythematosus in all of its manifestations has been largely empirical, and successful therapeutic results in the severer forms of the disease have not been frequent. In the past few months drugs that heretofore have had only limited clinical investigation have come into prominence in the dermatologic literature, and this investigation has been principally in the diseases of collagenous tissue, among which competent authorities place lupus erythematosus.[2] One of these drugs is para-aminobenzoic acid which was introduced for the treatment of lupus erythematosus by Zarafonetis et al.[3, 4] Little is known about the pharmacodynamic action of PABA. It is known, however, that it is a sulfonamide antagonist, that it is an effective sun screen,[5] that it detoxifies indol, and that it is effective in the treatment of some of the rickettsial diseases.

Presented at the Sixty-ninth Annual Meeting of the Louisiana State Medical Society, May 1948.

The case that is being reported is classified as subacute disseminated lupus erythematosis. It is felt that this report is important because the prognosis for this patient prior to PABA therapy was regarded as extremely poor and on institution of this form of treatment the patient exhibited an unexpected and remarkable clinical remission.

CASE REPORT

O. M., 38 years old, white male, was first seen on August 31, 1948. At that time the disease had been present for six years. He first became aware of a cutaneous abnormality in 1943 while he was a serviceman, when after prolonged exposure to the sun he became severely sunburned and the sunburn persisted for several weeks. This caused him no great inconvenience until March 1948 while painting the outside of a house. At that time blisters appeared on his hands, spreading to the face, forearms, arms, neck, and chest, in a period of three to four weeks. He consulted his local physician who gave him a series of intramuscular injections of unknown nature but these failed to influence the course of the disease. For the five months prior to admission the patient stated that he had been having daily bouts of fever which he recorded as high as 104° F. on a clinical thermometer. He also experienced moderately severe joint pains, especially in the shoulder region during the five months before admission.

The patient's past history revealed that he had had typhoid fever in 1934 and syphilis in 1925. For the latter he received seven intravenous injections. Numerous serologic tests for syphilis had been negative since that time. His family and marital histories were not contributory. On admission to the hospital the patient's temperature was 99° F., pulse 100 per minute, and blood pressure 100 mm. systolic and 60 mm. diastolic. At that time he appeared chronically ill and emaciated. On his arms, forearms, front and back of neck, face, and dorsum of hands there were erythematous, scaly, papular lesions that coalesced to form plaques. Examination of the individual lesions revealed telangiectasis, pigmentation, loss of hair, and atrophy of the skin to produce a picture not dissimilar to poikiloderma. There was a generalized shotty, nontender lymphadenopathy. Examination of the heart, lungs, abdomen, peripheral

and cranial nerves, as well as the eyes, ears, and mucosa were not remarkable.

Laboratory findings: On admission serologic tests for syphilis were negative. A urine specimen was reported as having 10-16 erythrocytes per high power field but was otherwise negative. Subsequent urine examinations were within normal limits. Serum proteins were 5.90 Gm. per cent, with 3.8 Gm. globulin, and 2.1 albumin. Blood creatinine was reported as 1.2 mg. per cent. There were 3,900,000 erythrocytes per cu. mm. of blood and 6,150 leukocytes with a differential count of 43 per cent lymphocytes, 34 per cent polymorphonuclear leukocytes, 5 per cent monocytes and 18 per cent eosinophiles. A roentgenogram of the chest was reported as showing no evidence of pulmonary pathology. A specimen of skin obtained by biopsy was reported as lupus erythematosus.

The patient's hospital course was uneventful, his temperature remaining between 99° F. and 100.5° F. until September 9, his ninth hospital day, when he began to have daily exacerbations of fever to 102 and 103° F. During this time only general supportive treatment, including liver extract, vitamins, and bismuth subsalicylate, was administered. Triweekly white blood cell counts up to this time had been between 5,000 and 10,000 per cu. mm. with a persistent moderate increase in eosinophiles. On the twenty-eighth hospital day it was noted that the patient appeared extremely ill and the cutaneous lesions had begun to disseminate, bright red lesions appearing under the nail plates, on the finger tips, palms, and over the abdomen. These lesions represented capillary dilatations as they could be obliterated by pressure. At this time the patient was having frequent bouts of fever up to 104° F. and the joint pains which had improved during the early part of his hospital stay had become much worse. Thirty-seven days after admission PABA was begun. He was given 10 grams daily by mouth in five equally divided doses. The bright red skin lesions began to fade in two days and had completely faded in twelve days. The daily bouts of high fever persisted, however, and the leukocyte count fell to 3,000 per cu. mm. It was felt that PABA might be causing the leukopenia and the drug was discontinued after fifteen days. A transfusion of 500 cc. of whole blood was given at this time in an effort to correct the leukopenia and the persistent anemia. Two days after the discontinuance of the PABA therapy the patient's temperature became normal and remained nearly so until discharge on November 19, 1948, eighty days after admission. A total of 150 Gm. of PABA had been given to this patient in fifteen days. He has been observed continuously since the time of discharge and has remained well with no new exacerbations of his skin disease, the only abnormal laboratory findings being a persistently elevated sedimentation rate, between 18 and 35 mm. per hour corrected, and a marked sensitivity to ultraviolet light. On testing, a minimal erythema could be produced on his skin in one-third the normal reacting time of several controls of similar complexion. In the last few weeks PABA therapy was reinstituted in doses of 10 grams daily by mouth and the patient retested for light sensitivity. The hypersensitivity to ultraviolet light was not influenced.

SUMMARY AND CONCLUSIONS

1. A case of subacute disseminated lupus erythematosus treated with PABA is presented with the physical and laboratory findings described in detail.

2. PABA, while not effecting a cure, is thought to have caused remarkable regression of the skin lesions in the case reported.

3. PABA, has not altered the patients' fundamental light sensitivity, nor did it influence the prolonged hyperpyrexia.

4. It is suggested that PABA is a valuable drug in the treatment of disseminated lupus erythematosus, but as a sole therapeutic agent it cannot be relied upon to cause remission of all aspects of the disease.

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DISCUSSION

Dr. Leslie K. Mundt (New Orleans): When Dr. Bradley asked me to discuss his paper, I agreed to do so but only after informing him of my extremely limited personal experience in the treatment of lupus erythematosus with para-aminobenzoic acid.

As you know, for purposes of discussion and teaching, lupus erythematosus is ordinarily divided into four groups: (1) discoid lupus in which the lesions are localized and confined to the face, scalp, or mucous membranes; (2) chronic disseminated discoid in which the plaques are widespread without systemic involvement; (3) subacute disseminated in which systemic involvement is exhibited; (4) and acute disseminated lupus erythematosus.

I have personally treated 2 cases of disseminated discoid lupus erythematosus with PABA. The first case was disappointing in that no clinical response at all was noted. In retrospect, I now believe treatment failure can be attributed to insufficient dosage administered over too short a

period of time. The second case, also one of chronic disseminated discoid, is now under treatment and is showing improvement under the recommended larger dosage.

The original work of PABA in the treatment of lupus erythematosus was done at Ann Arbor, Mich. This group reasoned along the following lines: (1) It is well known that exposure to ultraviolet light may exacerbate lupus erythematosus; (2) sensitivity to sunlight is also encountered in patients receiving sulfonamides; (3) PABA and sulfonamides are metabolic antagonists; (4) therefore, PABA might produce a beneficial effect in lupus erythematosus.

As I understand it, the drug seems to be least effective in the two extremes of the disease; namely, the benign discoid form and the frequently fatal acute disseminated variety. Results in chronic disseminated discoid lupus erythematosus have been more encouraging and the best results have been attained in the subacute disseminated forms. Dr. Bradley's paper attests to this. It should be remembered that lupus erythematosus is an unpredictable disease and the causal relationship between therapy and response is not easy to evaluate. However, in the 18 cases reported by Zarafonetis, Grekin and Curtis the improvement following PABA was consistent enough to be convincing.

The drug apparently is not without danger. Leukopenia, drug fever, rash, fatigue, and weakness must be anticipated. One case of fatal toxic hepatitis has been reported. The glycosuria encountered frequently in patients receiving 18 or more grams daily of the drug represents a renal glycosuria and is of no clinical significance.

Rein treated 13 unselected cases of lupus erythematosus and found the drug of no value. I believe, however, the results to date are encouraging enough to warrant additional studies with the drug.

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THE X-RAY IN THE DIAGNOSIS OF TUBERCULOSIS*

J. E. BLUM, M. D.
GREENWELL SPRINGS

Today the x-ray is being used more and more to aid in the diagnosis of tuberculosis. Most states have photofluorographic units and some hospitals are now using this device to screen all admissions. Many physicians have, or have access to, x-ray equipment. The tendency to depend on x-ray for diagnosis, leaving out the other important features of the case,—history, physical and laboratory work, is greater than formerly. Being tuberculosis conscious is commendable, but making the diagnosis on a single film is not scientific. Inaccurate diagnosis may work hardship on the individual. Tuberculosis is still a stigma to the laity.

There are many conditions which on x-ray film simulate tuberculosis. The pneumonias, histoplasmosis, carcinoma, sarcoidosis, pneumonoconiosis, lung abscess, and various other diseases can be erroneously called tuberculosis.

To make the diagnosis, a careful history and physical examination, laboratory and x-ray, must be studied together. If the physician depends on history alone, 80 to 90 per cent of the cases are far advanced by the time a diagnosis is made. Rales may or may not be present on physical examination. Chromogenic nonpathogenic acid-fast organisms may be found in the sputum. Soft shadows on a single film may mean several conditions, as outlined above. Thus, it is seen that a good x-ray with the other factors is needed for diagnosis.

ESSENTIAL FACTORS WHICH MAKE IT POSSIBLE TO TAKE A GOOD X-RAY PICTURE

1. Miliamperage (M.A.) passing through the tube.
2. Kilovoltage (K.V.) applied to the tube.
3. Time of exposure.
4. Distance (target-film).
5. Approximation of part to film.
6. Immobilization of part.
7. Uniformly sensitive films and screens.
8. Standard positions.
9. Proper dark room technic.

The photographic effects may be represented by $P.E. = \frac{M \times A \times T \times K \times V^2}{D^2}$.

The above may seem academic, but since many physicians are taking and processing their own x-rays, I feel the time is appropriate to point out many faults and how to correct them.

1. Milliamperage. Too frequently films are taken with small portable units and those advertised as capable of taking chest films. The Greenwell Springs Hospital uses 200 milliampers for routine chests and 100 milliampers for planigraph.

2. Too frequently, the kilovoltage is not

*Read before the Sixty-eighth Annual Meeting of the Louisiana State Medical Society, Monroe, April 14, 1948.

right, either too high or too low, unless of course, a photoelectric densiometer is used. For photofluorography the photoelectric cell is used. Otherwise, obstetrical calipers are used to measure the thickness of the chest. The same spot on each individual should be used, for example, the angle of Louis.

3. 0.2 second is used unless the Potter Bucky diaphragm is not used and, then 0.1 second is used. The vertical Potter Buckey is routine at Greenwell Springs Hospital.

4. Six feet is the distance used, since there is less distortion and the rays are almost parallel. Shorter distances tend to distort the shadows of the chest; the heart is larger, as are cavities and spots. One can hardly compare two films taken at different distances.

5. The part to be examined must be close to the film. There is marked difference if the lesion is in the left chest and a right lateral is taken. Also, the difference in E. P. A. and E. A. P. is striking enough in my opinion to warrant a change in the usual position since 75 to 90 per cent of lesions are in the posterior half of the chest. E. A. P. gives more information. This can also be nicely demonstrated by fluoroscopy —have the individual's back to the screen.

6. Immobilization of the part is essential, as movement causes a poor film. Even the motion in the heart in a long exposure is noticeable.

7. One should use the same brand of film (if possible) and, at least, the same speed screens.

8. The standard positions of E. P. A., E. A. P. left, and right lateral and obliques are used, and naturally the position of the tube must be centered on the center of the casette and patient. The patient is instructed to take a deep breath and hold until exposure is made. Sometimes in marginal pneumothoraces, the lung fills the pleural cavity and no space is seen. Consequently, exposures in expiration are made at intervals, remembering that the diaphragms are elevated and the lower third of the lungs may appear as containing exudative lesions.

9. The casette must be opened in darkness and a good safe light used, or fogging may occur. Develop for three and a half minutes in solution which has been agitated and kept at 68° F. Solutions should be made fresh at least every sixty days. Replenisher may be used, only 3 gallons for a 10 gallon tank, enough solution to completely cover the film on hangers. Fix from five to fifteen minutes, depending on age of fixer. Wash in *running water* for at least thirty minutes. The care of casettes is important. When dirty spots appear on completed films, the interior of the casettes should be inspected. Screens may be brushed with a camel hair brush and washed with ivory soap and water. Care should be used in placing films in casettes so as not to close casette on film.

Besides the E. P. A. and E. A. P., laterals right or left, remembering that the lesion should be close to the film, are used to locate lesions and adhesions. Obliques also are very helpful in locating lesions in the left chest, and adhesions.

The planigraph in my estimation, is far superior to stereoscopy. Since few machines can take two exposures in the same phase of respiration and cardiac cycle and since few people can truly see stereoscopically, body section x-ray should be used more and more as the equipment becomes better known.

CONCLUSIONS

1. The x-ray taken with the essential factors correctly applied, should help to further the early diagnosis of tuberculosis.

2. Too frequently, one, several and sometimes all of the essential factors are overlooked.

3. Too much emphasis is being placed on a single x-ray. Sometimes several must be taken to complete the diagnosis.

4. Body section x-ray is to play a more important part in diagnosis.

5. The laxity in not applying the essential factors must be corrected so that readable films will aid in the diagnosis of tuberculosis.

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THE TIME IS NOW—
THE RESPONSIBILITY IS YOURS

By DR. H. WHITNEY BOGGS,
Secretary Louisiana Physicians Service

On September 19th, and continuing for two weeks, the Blue Shield and Blue Cross Plans of Louisiana will conduct a statewide Individual Enrollment Campaign. During this period, persons not covered by these plans under a group contract, may enroll as individuals or in family groups by paying a three month premium in advance.

You all know—but too many of you are inclined to forget—that the Louisiana State Medical Society, has made possible the formation of a voluntary medical-cost insurance program, operated on a non-profit basis, owned and endorsed by the State Medical Society and officered by and directed by doctors who donate their time.

Much criticism, and recently some praise, has been leveled at the men whose time and effort have been given to make L. P. S. a success. One of the most frequently voiced criticisms has been, "Why can't *all* the people buy insurance—why must it be sold only to groups?" To this we have been forced to reply that when the financial position of the company justified it, and our actuarial experience was such that we could anticipate and plan on our utilization in an orderly manner, then, and only then, could we enroll individuals and family groups without the necessity of their meeting group requirements. We have all worked hard to reach this goal and we are happy to say that, in good time, it has been reached—The Time is *Now!*

But that is only *half* the battle. Our plans are laid, policies printed and available, state-wide advertising campaigns mapped out, salesmen—those that we have—ready, the Blue Cross units cooperating in every way. On the face of things, it looks like a lead-pipe cinch to succeed. But will it?

Well, now—that *depends*. L. P. S. has had some rough sledding financially, but our position now is excellent—we are paying our way, and have recently improved our contract a great deal, because our profits went into reserves for the benefit of the public—the insured.

Our enrollment in the first six months of 1949 has been excellent—way beyond expectations, but we have been delayed many times—by the merger proceedings of the three upstate Blue Cross plans into the now functioning Louisiana Hospital service, for example. But our greatest single handicap, and that of our Blue Cross allies, has been the lack of competent salesmen to present our plan to employers.

That brings us up to now—*You wanted* individual enrollment. Now you *have* it. But, what are you going to do about it? Will *you* sell *your* Insurance, to *your* pa-

tients, on *your* time? Are you willing to devote just 5% as much of your time to making our first Individual Enrollment Period a success, as your L. P. S. directors and officers donate of theirs in *your* behalf to make *your* insurance company successful?

You may say, "But I'm a physician—*not* a salesman" — Very true, as far as it goes — but unless we all do a selling job, someone else will have sold the American People an inferior bill of goods, marketed by the believers in the stultifying philosophy of "Something for nothing, from the cradle to the grave."

So, Doctors, *be* salesmen for a two week period. Use the material which will be sent to all of you. Urge *your* patients to get Blue Shield—Blue Cross coverage—only then, will *you* be doing *your* part. The plans are laid—the time is now!—but the responsibility is *yours!*

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HAS PRIVATE MEDICINE FAILED TO IMPROVE PUBLIC HEALTH?

By DR. WILLFORD I. KING*

In the last two decades, maternal deaths connected with child-bearing have declined to only about one-fifth of the rate prevailing in 1930. Here we have a real triumph of medical science.

One can gain a more inclusive view by considering the average expectation of life of young women at the age of 25. In 1900, the average white girl of that age would live 40 years. Her granddaughter in 1946 could look forward to 46 more years—a gain of 6 years. The average colored girl of the same age in 1900 had an expectation of life of 34 years. In 1946, the corresponding figure was nearly 42 years—an extension of almost 8 years. Again, the figures show that health gains have been at least as marked among the colored as among the white population.

But is it not true that most people in poor States like Mississippi are almost completely lacking in modern medical care. Official Government figures show the per thousand death rate for Mississippi to have been 12.7 in 1919 and only 9.2 in 1946—a drop of 3.5 points. During the same period in New York—the richest State in the Union—the death rate fell from 13.9 to 11.1—a decline of 2.8 points—materially *less* than in Mississippi.

What do all these figures indicate? Assuredly, they show that health progress under the existing system of treatment has been amazing. However, one must not jump to the conclusion that the average family does not need sickness insurance to take care of the heavy financial burden which may result in case of serious illness. Such insurance should be compulsory. But this does not mean that the Government must go into the insurance business. Sound private insurance companies are always seeking new policyholders. The Blue Cross and similar cooperative insurance concerns are expanding rapidly. Their charges, covering both hospital and medical service, are so low that the ordinary workingman can meet them without undue hardship. Why, then, do our political leaders feel Government entry into the sickness insurance field to be so imperative?

The obvious answer seems to be that such extension of Government activity will furnish many lucrative jobs for loyal party henchmen, and will give more power to bureaucrats. They naturally favor any scheme which will make the United States Treasury buy votes for them. How does this arrangement appeal to you who, as a taxpayer, must help to keep the Treasury in funds? Furthermore, will you enjoy having the Government control your medical service? These questions are worth thinking over.

*Economics-Professor Emeritus, New York University; author of many articles and books on economics, including recent volume, "The Keys to Prosperity."

THE TIME IS NOW—THE RESPONSIBILITY IS YOURS.

ORGANIZATION SECTION

The Executive Committee dedicates this section to the members of the Louisiana State Medical Society, feeling that a proper discussion of salient issues will contribute to the understanding and fortification of our Society.

An informed profession should be a wise one.

REPORT OF AMA HOUSE OF DELEGATES MEETING

President and Executive Committee,
Louisiana State Medical Society,
New Orleans.
Gentlemen:

At ten o'clock on the morning of Monday, June 6, in Atlantic City, the House was called to order by the Speaker, Dr. Borzell. The Chairman of the Reference Committee on Credentials reported 152 accredited members. Minutes of the interim meeting, held in St. Louis, were adopted as published.

Selection of the recipient of the distinguished service award was between Dr. Alfred Blalock, of Baltimore, Dr. Seale Harris, Birmingham, and Dr. Shield Warren, Austin. When the final vote was counted Dr. Seale Harris was declared the winner and was presented this award.

Two extra committees were appointed. One of these was the Committee on Prepayment Insurance and Medical Plans and to this committee Dr. J. Q. Graves was appointed.

Following remarks by the President and introduction of the President-elect, Dr. Elmer Henderson reported for the Board of Trustees. Dr. Henderson's statement in regard to the Editor of the Journal, Dr. Morris Fishbein is produced in full as follows:

"The Board of Trustees is aware of the criticism of the editor, coming from within and from without the profession. The Board recognizes that the public has come to believe that the editor is a spokesman of the Association. The membership undoubtedly wishes the elected officials to speak authoritatively on all matters of medical policy.

"Against the time when the editor retires, Dr. Austin Smith has for some months been in training as the assistant editor, and the talent of the editor will be retained for the present under the control of the Board of Trustees.

"In view of the increasing responsibility of the editor and reorganization of the department, the Board of Trustees has decided on the following points:

"1. The editor will completely eliminate speaking on all controversial subjects, both by platform and by radio. Approval of all speaking engagements will be made by the executive committee.

"2. Elimination of all interviews, including press conferences, and statements by Dr. Fishbein, except on scientific subjects.

"3. Editorials on controversial subjects will be supervised by the executive committee.

"4. Complete information as to these activities will be reported to the members of the House of Delegates.

"5. There will be permanent elimination of 'Diary in Tonics and Sedatives' (the Fishbein column).

"6. Plans for the training of a new editor in an orderly manner, including retirement of the present editor, will be formulated.

"The Board of Trustees of the American Medical Association announces that plans have been formulated for the retirement of Dr. Morris Fishbein as editor of 'the Journal of the American Medical Association' at an appropriate time. For thirty-seven years Dr. Fishbein has served the AMA well and faithfully. The Journal of the AMA is an enduring monument to his genius and devotion. His activities have been extended far beyond his immediate duties as an editor and the Board desires to pay tribute to his many accomplishments in other fields.

"The Board finds that serious dislocation would result from any sudden replacement. With this in mind, a reorganization of the editorial staff is under way, so that his retirement, when consummated, will not result unfavorably for ventures of the association."

Under the head of new business a great number of resolutions, referring to all types and problems of medicine were presented. Following this recess was taken.

The first order of business for the afternoon session was a report by the firm of Whitaker and Baxter. After listening to this report your delegates feel that the public relations and publicity of the AMA are in exceptionally good hands. It was suggested that a large size picture of "The Doctor", by Sir Luke Fildes, with the inscription "Keep Politics Out of this Picture" be sent to all doctors for display in their office. There were some very large billboard signs of this picture displayed on the boardwalk in Atlantic City and they were very well received. The picture is also to be used in every other way possible, for instance in moving picture houses, as slogans on postage meters, etc.

For the first time in some years Wednesday was open entirely for committee meetings and no special sessions of the House were held.

The resolution in regard to increasing payment for life insurance examinations was again dis-

cussed and finally referred back to the secretaries of the various state medical societies for further study and report.

The Committee on Liaison with the American Red Cross Blood Bank was continued and it was reported that by July 1, 1949 there would be 34 Red Cross Blood Centers in operation. A questionnaire has been sent to each of the 6,400 registered hospitals to learn where all blood banks are located and 5,600 replies have been received. A second questionnaire is being prepared to determine such points as capacity, type of organization, material used and charges made.

The resolution on appointment of a committee to study the problem of displaced physicians generally in furthering the setttlement of these persons in the different states was referred to the Board of Trustees for further study.

A resolution to discontinue the annual general practitioner award, as introduced by the Connecticut State Medical Society, was defeated.

It was proposed that a study be made as to the possibility of admitting interns to membership in the AMA. It appeared, from the discussion, that this idea was well thought of and every effort will be made to provide for intern membership.

Attention was called to the fact that the Constitution has previously required that a doctor moving from one state to another should make application for membership in the state to which he has moved within one year or be dropped from the rolls of the AMA. This requirement has now been changed making it necessary to apply for membership in the state to which the doctor has moved within six months time.

A new section on physical medicine and rehabilitation was approved.

Disapproval was voiced against coverage of individuals, especially doctors under the Social Security Act.

A revised Code of Ethics for the medical profession was adopted, after several years of study, and we believe it will prove quite satisfactory. At the same time another Code of Ethics for the World Medical Organization was proposed.

The Scientific Assembly Council was increased to seven members, one of whom shall be a general practitioner, elected by the House of Delegates upon nomination by the Board of Trustees. The term of office of each member of this Council shall be seven years.

A recommendation was made that a two-year internship for general practitioners be established in hospitals and that general practitioners be given rights of staff members in all hospitals.

The following twelve-point program of the AMA was approved:

"1. Creation of a federal department of health of cabinet status with a secretary who is a doctor of medicine, and the coordination and integration of all federal health activities under this department, except for the military activities of the medical services of the armed forces.

"2. Promotion of medical research through a national science foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.

"3. Further development and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with extension as rapidly as possible into rural areas. Aid through the states to the indigent and medically indigent by the utilizations of voluntary hospital and medical care plans with local administration and local determination of needs.

"4. Establishment in each state of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.

"5. Encouragement of prompt development of diagnostic facilities, health centers and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.

"6. Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

"7. The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.

"8. Health education programs administered through suitable state and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.

"9. Provision of facilities for care and rehabilitation of the aged and those with chronic disease and various other groups not covered by existing proposals.

"10. Maintenance of existing high standards of medical care for veterans including extension of facilities where need can be shown. Where practical, care of the veteran should be in his own community by a physician of his own choice.

"11. Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highways, home and on the farm.

"12. Adequate support with funds free from political control and regulation of the medical and allied professional schools."

The Committee on Prepayment Medical Plans submitted the following 20 points as suggested principals for lay sponsored voluntary health plans.

which were approved by the House of Delegates:

"1. The Plan shall be non-profit, paying no dividends to beneficiaries or others; all surplus earnings shall be devoted either to improving the services, to making compensation of physicians and other staff members more adequate for their responsibilities and services, to purchasing facilities and equipment, to increasing the scope of benefits, or to building adequate reserve funds. All income to the Plan shall be devoted to services for beneficiaries.

"2. The Plan shall comply with the Principles of Medical Ethics of the American Medical Association which provide that it is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body of individual employing him.

"3. If incorporated the Plan shall be adequately financed and organized without capital stock.

"4. The Plan shall be operated under an autonomous administration or trust, with segregated funds, and shall be devoted exclusively to the provision of health service.

"5. Promotion, sales, organization and administrative expense of the Plan shall be kept at a minimum as judged by the accrediting body.

"6. The quality of medical service shall be maintained at the highest possible level. All participating physicians shall be doctors of medicine duly licensed to practice medicine in any state in which the Plan operates. Each physician engaged in the practice of a specialty shall be required to have adequate qualifications for that specialty. The personnel and facilities of the Plan shall be adequate to insure a high quality of medical care.

"7. The Plan shall provide all services as set forth in the agreement with the beneficiary. When in the opinion of the medical staff, a professional service set forth is not available because of an emergency or because of the need for highly technical procedure, or for any other reason, then such service shall be otherwise provided by the Plan.

"8. The Plan, in its agreement entered into with the beneficiary and which shall be distributed to each beneficiary, shall state clearly the services and benefits to be provided and the conditions under which they will be provided. All exclusions, limitations, waiting periods and deductible provisions shall be clearly stated in the argreement with the beneficiary and in promotional and descriptive literature.

"9. The Plan shall, in its agreement with the beneficiary, state clearly the amount of dues or subscription to be paid. The amount of dues or subscription shall be adequate to provide for the benefits and services offered and to insure proper financing of the risks involved.

"10. No promotional material shall invite attention to the professional skill, qualifications or attainments of the physicians participating in the Plan.

"11. Participating physicians may be compensated in any manner not contrary to the Principles of Medical Ethics of the American Medical Association relating to contract practice.

"12. Any duly licensed physician in the community who wishes to participate in the Plan, who meets its professional and personnel standards, and who agrees to abide by its terms and the requirements of its beneficiaries, shall be admitted to the Plan.

"13. The names of all participating physicians of the Plan shall be made available to the prospective beneficiary. The beneficiary shall, within reasonable geographic and professional limitations, have free choice among participating physicians.

"14. There shall be no interference by the governing body with the medical staff in the practice of medicine. The traditional and confidential relationship of the physician and patient shall be preserved.

"15. Adequate provision shall be made for effective participation of the medical staff in the deliberations of the governing body. It is recommended that the membership of the governing body include representatives of the medical profession.

"16. All services rendered by the participating physician, not included in the beneficiary's contract, shall be payable by the beneficiary to the participating physician on a fee for service basis.

"17. The method of operation of any hospital owned or under contract to the Plan shall be in accordance with sound public policy.

"18. The plans shall provide for like rates, benefits, terms and conditions for all persons in the same class.

"19. Investment of reserve funds shall be made only in securities deemed prudent for such purposes.

"20. Any Plan desiring approval under these principles shall agree to such periodic reviews and to abide by such regulations as may be deemed necessary by an appropriate accrediting body of the American Medical Association in consultation with representatives of the sponsors of the Plan."

On Thursday Dr. Abel, a British Surgeon, was granted the floor to discuss socialized medicine in England. Unfortunately his time had to be limited, however the talk he was permitted to make was extremely interesting. He brought out the point that in the hospitals of England today there is a waiting list which requires a patient to wait twelve to eighteen months before admitted to the hospital. He tried to impress the delegates with the fact that we should advocate insurance for those who cannot pay but we should permit those able to meet their own obligations to have the power to contract for their own bills. He ably summed up

the British idea in one sentence when he said: "The British government does not trust the people to spend their own money but takes it from them and spends it for them."

On Thursday afternoon the election of officers took place. It was quite unusual that one of the New York newspapers stated in a Thursday morning edition that the new president of the AMA had been elected, before the nominations were made. Dr. Elmer Henderson, of Kentucky, was elected president, without opposition. We would like to call your attention to the fact that Dr. Francis J. L. Blasingame, of Texas, was elected to fill the place of Dr. Henderson on the Board of Trustees. The other officers elected are as follows: Dr. James Francis Norton, New Jersey, Vice-President; Dr. Frank Borzell, Pennsylvania, Speaker of the House; Dr. James R. Reuling, New York, Vice-Speaker of the House; Dr. Louis H. Bauer, Member of the Board of Trustees.

Your delegates feel that a lot was accomplished at this meeting and that future events will show the wisdom of some of the action of the House of Delegates at this session.

Respectfully submitted,
Val H. Fuchs, M. D., Delegate
J. Q. Graves, M. D., Delegate

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REPORT OF THE RURAL HEALTH COMMITTEE MEETING

Held in Alexandria, Louisiana
July 17, 1949, 2:00 P. M.

There was a joint meeting of the Rural Health Committee of the Louisiana State Medical Society with the Rural Health Committee of the Farm Bureau. The following members of the Rural Health Committee of the Louisiana State Medical Society were present: Dr. Guy R. Jones, Dr. M. C. Wiginton, Dr. Lorenz Teer and Dr. J. P. Sanders. There was full attendance of the Rural Health Committee of the Farm Bureau and Miss Bascher of the Agricultural Extension Service and Dr. Trois Johnson were guests.

A considerable amount of discussion centered around the possibiiity of changing the name of the Rural Health Council of Louisiana. It was finally decided that we recommend to the Council that it drop the sole sponsorship of the Farm Bureau. Originally, when the Rural Health Council started, it was necessary that it have the backing of some one organization and that was the reason that it was called the Rural Health Council of the Farm Bureau. It was felt by the two committees that after two years of active operation the Rural Health Council was sufficiently strong to stand on its own; that since approximately thirty organizations were represented in the Council, it would be best to drop the name of the "Farm Bureau." It was felt that the Farm Bureau and the Louisiana State Medical Society will have to continue active participation in the Rural Health Council, in order to keep it functioning.

Plans for the future were discussed regarding a Rural Health Council meeting sponsored largely by the Louisiana State Medical Society. The Rural Health Committee of the State Medical Society felt that the State Medical Society would be willing to sponsor such program at anytime the Rural Health Council requested it. The coming Rural Health Council meeting to be held in Baton Rouge on August 16th and 17th, 1949, was discussed at some length and the Rural Health Committee went on record in requesting that all doctors in the state of Louisiana attend this important meeting, if at all possible.

J. P. Sanders, M. D.

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LOUISIANA STATE MEDICAL SOCIETY NEWS

CALENDAR

PARISH AND DISTRICT MEDICAL SOCIETY MEETINGS

Society	Date	Place
East Baton Rouge	Second Wednesday of every month	Baton Rouge
Morehouse	Second Tuesday of every month	Bastrop
Natchitoches	Second Tuesday of every month	
Orleans	Second Monday of every month	New Orleans
Ouachita	First Thursday of every month	Monroe
Rapides	First Monday of every month	Alexandria
Sabine	First Wednesday of every month	
Second District	Third Thursday of every month	
Shreveport	First Tuesday of every month	Shreveport
Vernon	First Thursday of every month	

CANCER RESEARCH FELLOWSHIP

The American Cancer Society has announced that Dr. Richard H. Corales, Jr., of New Orleans, La., assistant resident in neurosurgery, at the Duke University School of Medicine, has been awarded a Damon Runyon Clinical Research Fellowship. The award, for one year, from July, 1949 to July, 1950, was made on recommendation of the Committee on Growth of the National Research Council.

Dr. Corales, a graduate of Tulane University School of Medicine, will participate in a Duke Uni-

versity research program, in the field of brain tumors, approved by the National Research Council, under the direction of Dr. Barnes Woodhall and Dr. Guy Odom, professor and assistant professor of neurosurgery.

NEWS ITEM

Dr. F. L. Jaubert was elected President of the Medical Staff of the Sara Mayo Hospital at its annual meeting held in June.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION

The National Gastroenterological Association will hold its 14th Scientific Session at the Somerset in Boston, Mass., on October 24-26, 1949.

Among the outstanding speakers to present papers at the Convention are Dr. Owen H. Wangensteen, Professor of Surgery, University of Minnesota Medical School; Dr. Frank Lahey, Lahey Clinic, Boston, Mass.; Dr. William B. Castle, Boston, Mass.; Dr. George Crile, Jr., Cleveland, Ohio; Dr. Maxwell Finland, Boston, Mass.; Dr. J. M. T. Finney, Jr., Baltimore, Md., and Lord Alfred Webb-Johnson, President of the Royal College of Surgeons, London, England, who will be a guest of honor at the banquet to be held on Tuesday evening, October 25, 1949.

At the Annual Banquet to be held at the Somerset, the winner of the National Gastroenterological Association's 1949 Prize Award Contest for the best unpublished contribution on Gastroenterology or an allied subject, will receive the prize of $100.00 and a Certificate of Merit.

Immediately following the Convention on October 27, 28, 29, 1949, the Association is sponsoring a course in Gastrointestinal Surgery at the Boston City Hospital.

Further information concerning the program and details of the course may be obtained by writing to the Secretary, National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.

The annual meeting of the Board was held in Chicago, Illinois, from May 8 to 14, 1949, at which time 236 candidates were certified.

New Bulletins, incorporating changes made at the recent meeting, are now available for distribution upon application and give details of all new regulations.

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States and Canada on Friday, February 3, 1950. Application may be made until November 5, 1949. Application forms and Bulletins are sent upon request made to American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

MEETING OF THE INTERNATIONAL SURGICAL SOCIETY

The International Surgical Society (Societé Internacionale de Chirurgie) will meet in New Orleans, October 10th to 15th inclusive. It is one of the oldest of the international medical societies, having been founded in 1902. Distinguished presidents include such famous American surgeons as Matas and Keen, and others from abroad as Kocher, Depage and Czerney.

A large attendance, including representatives from many foreign countries, is expected. The proceedings will be in their respective languages. The headquarters will be the Roosevelt Hotel.

WOMAN'S AUXILIARY TO THE LOUISIANA ACADEMY OF GENERAL PRACTICE

Announcement of officers elected at the recent convention, confirmation of councillors to promote membership in the various districts, and appointment of chairmen of standing committees, comprise the highlights of activity in the Woman's Auxiliary to the Louisiana Academy of General Practice.

Mrs. D. B. Barber, of Pineville, La., will guide the affairs of the women as president of the group this year, while her husband assumes a similar position, heading the men's association. Mrs. George D. Feldner of New Orleans is president-elect, Mrs. John W. Atkinson of Gretna, vice-president, Mrs. Frank H. Davis of Lafayette, recording secretary, Mrs. N. M. Brian of Alexandria, corresponding secretary, Mrs. Esmond A. Fatter of New Orleans, treasurer, and Mrs. Daniel J. Murphy of New Orleans, parliamentarian.

Chairmen of standing committees include Mrs. J. A. White, Jr., of Alexandria, in charge of Social Relations, Mrs. John W. Atkinson of Gretna, to promote membership; Mrs. Charles Horton of Franklin as historian, and Mrs. Edwin R. Guidry of New Orleans, in charge of publicity.

Councillors are: First District, Mrs. Nicholas J. Chetta and Mrs. Bruno Mancuso of New Orleans; Second District, Mrs. Earl J. Clayton of Norco; Third District, Mrs. W. A. K. Seale of Sulphur, La.; Fourth District, Mrs. J. M. Bodenheimer, Shreveport, La.; Fifth District, Mrs. John Bostic, Gilbert; Sixth District, Mrs. Thomas Y. Gladney, Baton Rouge; Seventh District, Mrs. E. Rigsby Hargrove, Oakdale, and Eighth District, Mrs. C. P. Herrington, Alexandria.

The Advisory Board consists of Dr. Joel B. Gray, New Orleans, Dr. J. P. Sanders, Shreveport, Dr. Janie M. Topp, Lake Charles, Dr. C. P. Herrington, Alexandria, and Dr. E. Rigsby Hargrove of Oakdale.

Plans being formulated for the organization of a national group at the convention meeting scheduled at St. Louis for February 22, 23 and 24, will be announced next month.

Mazie Adkins Guidry,
Chairman of Publicity.

BOOK REVIEWS

Synopsis of Neuropsychiatry: By Lowell S. Selling, M. D., Ph. D., Dr. P. H., F. A. C. P. 2d Edition. St. Louis, C. V. Mosby Co., 1947, pp. 56, illus. Price, $6.50.

This book is excellent insofar as it covers every clinical condition that might be encountered in neurology and psychiatry. The handling of controversial questions is done with reasonableness and according to generally accepted opinions.

However for the student who wants to understand theory and dynamics, this synopsis would be disappointing. No subject is clarified except at a clinical descriptive level. On that level it is comprehensive and detailed.

WALKER THOMPSON, M. D.

Text-Book of Public Health: By W. M. Frazer, O. B. E., M. D., Ch. B., M. Sc. D. P. H., and C. O. Stallybrass, M. D., Ch. B., D P. H., M. R. C. S., L. R. C. P. 12th ed., Baltimore, The Williams and Wilkins Co., 1948, pp. 571, illus. Price, $6.50.

This twelfth edition of the *Text-Book of Public Health* (formerly Hope and Stallybrass), only two years after the eleventh edition, is occasioned, in the authors' own words "by the increase in the number of medical students and to the resumption of D. P. H. courses, discontinued during the war." There is consequently little change in those chapters dealing with purely technical subjects. There is considerable change in those chapters dealing with administration because of the great amount of health legislation passed by the British Parliament in 1945 and 1946. These years saw the passage of the National Health Service Act, the Family Allowances Act, the National Insurance (Industrial Injuries) Act, and the National Insurance Act.

This textbook, as mentioned above, is designed for medical students and students of Public Health in Great Britain. Therefore, the policies and practices defined and discussed are those in effect in the British Isles. There is a great deal of basic information on physical subjects and environmental sanitation in relatively simple terms which students in the United States will find of interest and benefit. However, the textbook will be of most interest to the student of Public Health who will find here detailed discussions on powers and duties of the British Public Health system.

Factual data used throughout the book appear to be up to date though some of the clinical procedures described are no longer in use in this country. Terminology and brand names or trade names, where used, will not be familiar to readers in this country. With this in mind, however, the student will find much of value in the book.

WALDO L. TREUTING, M. D., M. P. H.

Recent Advances in Obstetrics and Gynecology: By Aleck W. Bourne, M. A., M. B., B. Ch., F. R. C. S., F. R. C. O. G., and Leslie H. Williams, M. D., M. S., F. R. C. S., F. R. C. O. G. 7th ed., Philadelphia, The Blakiston Co., 1948, pp. 326, illus. Price, $6.00.

The seventh edition of Recent Advances in Obstetrics and Gynecology, by Aleck W. Bourne, and Leslie H. Williams, contains six new chapters replacing the same number of chapters from the sixth edition. The chapters retained have been modified in accordance with more recent knowledge.

Part one deals with the following subjects in obstetrics: Nutrition in pregnancy and fetal development, weight changes and water retention. The chapter on anemias of pregnancy is a new addition and is a very excellent work. Chapters on anesthesia and analgesia in obstetrics, penicillin in obstetrics, lactation, vitamin K and hemorrhagic disease of the new-born, erythroblastosis, stillbirth and neonatal death, and radiology in obstetrics, have been thoroughly revised and modified according to recent advances.

Part two deals with the following subjects in gynecology: Cancer of the cervix uteri, stress incontinence, sympathectomy, penicillin in gynecology, radiological investigation and diagnosis, and x-ray therapy in gynecology.

All in all, the book is very comprehensive and well written.

ADOLPH JACOBS, M. D.

Brief History of the South Carolina Medical Association: Published by the South Carolina Medical Association, Charleston, 1948. Port., pl., illus., pp. 197.

Latest of the state histories of medicine is this brief but inclusive medical history of South Carolina. Beginning with a sketch of medicine in Colonial South Carolina, the earliest medical societies and institutions are described, followed by the development of state health activities, the growth of hospitals and medical publications, and the medical problems of today and the future. History of county societies is given in brief, as are short accounts of the establishment of specialty societies in the state and South Carolina's medical institutions. This volume will serve a very useful purpose as a contribution to the medical history of the South.

MARY LOUISE MARSHALL.

Take Up Thy Bed and Walk: By David Hinshaw. New York, G. P. Putnam's Sons, 1948. Pp. 262, illus. Price, $2.75.

This is the story of the Institute for the Crippled and Disabled in New York. It is particularly interesting in that it shows the results which may

be obtained by cooperative effort of all agencies having to do with rehabilitation—medical, physical, psychological, social and vocational. This Institute has helped some 25,000 physically handicapped men, women and children to find new reason for living.

MARY LOUISE MARSHALL.

Atlas of Peripheral Nerve Injuries: By William R. Lyons, Ph. D., and Barnes Woodhall, M. D. Philadelphia, W. B. Saunders Co., 1949. Pp. 339, plates. Price, $16.00.

This atlas is a monumental contribution to the knowledge and records concerning peripheral nerve injuries. The work is principally based on observations made at Walter Reed General Hospital and Halloran General Hospital on patients who sustained peripheral nerve injuries in World War II. A description of the clinical material used and the methods of fixing nerve tissue, is followed by a section devoted to normal peripheral nerve structure. Then there are sections showing the findings in the instance of completely severed nerves and nerve lesions in continuity. The many aspects of nerve suture, including time factors, reactions to suture materials and wrappers, and suture site neuromas are illustrated and described. The results of various types of nerve grafting are demonstrated and critically analyzed. Most of the illustrations, are in the form of excellent photomicrographs both black and white and colored. Clinical photographs both black and white and colored, preoperative, operative, and postoperative findings. Altogether, this publication is a masterpiece which will do lasting honor to everyone who had a part in its preparation.

AMBROSE H. STORCK, M. D.

The Fundamentals of Pulmonary Tuberculosis and Its Complications: By Edward W. Hayes, Editor. Springfield, Ill., C. C. Thomas, 1949. Pp. 464. Price, $9.50.

This book was sponsored by the American College of Chest Physicians as a textbook on the subject of pulmonary tuberculosis for the use of medical students, teachers, and practicing physicians. The editor and the various authors have gone far toward filling the real need for such a text. Although it is possible that one author could have written a more integrated volume of this size, the point of view of the writer of each chapter is of interest and value. The reader should realize, however, that some of the views expressed are peculiar to the individual authors and not always "opinions held by large groups of experienced observers," as stated in the introduction. For example, the favorable mention of Caulfield's inhibition reaction (no reference given) as a means of detecting tuberculosis will only serve to confuse the student, since this test has not been found of any value in the 24 years since its announcement. The bibliographies appended to the chapters are not edited either to avoid duplication or to remove references to outdated and unimportant methods. The compilation of books on the various phases of pulmonary tuberculosis at the end of the volume is an admirable feature. The illustrations of many of the chapters are excellent, but a more equal distribution of illustrated material would have been desirable. The format and typography are of the usual excellent quality provided by this publisher.

The book is recommended, with the above reservations, as a textbook for medical students and practitioners.

J. L. WILSON. M. D.

Nutrition and Diet in Health and Disease: By James S. McLester, M. D. 5th ed., Philadelphia, W. B. Saunders Co., 1949. Pp. 800. Price, $9.00.

There is a trite observation that there is no evil but that some good may be found in it. This has been evidenced by the many important medical observations and discoveries which have resulted from experience in World War II. This has in the main been responsible for the new and fifth edition of McLester's book on nutrition and diet in health and disease.

The newer concepts of treatment in important diseases, as peptic ulcer, cirrhosis, congenital heart failure, etc., have resulted in revised presentations.

Several chapters by collaborators have been entirely rewritten. Appended to each chapter is a good bibliography.

I. L. ROBBINS, M. D.

Mayo Clinic Diet Manual: By The Committee on Dietetics of the Mayo Clinic, Philadelphia, W. B. Saunders Co., 1949, pp. 329. Price, $4.00.

This has been done in the thorough and excellent manner characteristic of all work done at the Mayo

Clinic. Diets in health and disease are outlined, and the *raison d'être* and *modus operandi* are briefly mentioned. Casual sampling gives the impression that this is a worthwhile addition to all ordering and executing the diet of the well and the ill.

I. L. ROBBINS, M. D.

PUBLICATIONS RECEIVED

Duke University Press, Durham: The Compleat Pediatrician (Sixth Edition), by W. C. Davison, M.A., D. Sc., LL.D., M.D.

J. B. Lippincott Company, Philadelphia: New and Nonofficial Remedies—1949, issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association.

Charles C. Thomas, Springfield, Ill.; Neurology (4th Ed.), by Roy R. Grinker, M.D. and Paul C. Bucy, M.D.